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No. ___-___

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

ST. JAMES HOSPITAL,

Petitioner,

v.

MARGARET M. HECKLER, SECRETARY,
DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982, in retroactively precluding Medicare reimbursement for hospital costs incurred treating the indigent pursuant to regulations implementing the Hill-Burton Act, improperly infringes judicial power by legislatively overturning monetary judgments entered against the United States and violates the Fifth Amendment by (1) abrogating contractual obligations of the United States and (2) requiring private hospitals to operate at a loss.

2. Whether the Medicare program should bear its pro rata share of the cost of providing free care to the indigent, required by regulations implementing the Hill-Burton Act, when Medicare patients use the medical facilities constructed with Hill-Burton financing?

3. Whether the Secretary of Health and Human Services should be afforded deference in decreeing that bedside patient telephones are "personal comfort items" as that term is used in the Medicare Act, 42 U.S.C. § 1395y(a)(6), when the Secretary offers no evidence in support of the regulation and a hospital seeking pro rata reimbursement by the Medicare program offers overwhelming evidence that bedside patient telephones have therapeutic value.

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MARGARET M. HECKLER, SECRETARY,
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Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

The petitioner, St. James Hospital, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit, dated February 1, 1983. The Court of Appeals reversed the judgment of the United States District Court for the Northern District of Illinois.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 698 F.2d beginning at page 1337 and is reproduced in the appendix to this Petition, commencing at page 1a. The opinion and judgment of the United States District Court for the Northern District of Illinois is reported at 535 F. Supp. beginning at page 751 and is also reproduced in the appendix, commencing at page 1b.

JURISDICTION

The judgment of the Court of Appeals for the Seventh Circuit was entered on February 1, 1983. A timely petition for rehearing *in banc* was denied on April 1, 1983, and this petition for certiorari was filed within ninety days of that date. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

United States Code, Title 42:

§ 291c. The Surgeon General, with the approval of the Federal Hospital Council and the Secretary of Health and Human Services, shall by general regulations prescribe–

* * *

(e) that the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant; and (2) there will

be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

§ 1395x(b). The term "inpatient hospital services" means the following items and services furnished to an inpatient of a hospital and (except as provided in paragraph (3)) by the hospital –

(1) bed and board;

(2) such nursing services and other related services, such use of hospital facilities, and such medical social services as are ordinarily furnished by the hospital for the care and treatment of inpatients, and such drugs, biologicals, supplies, appliances, and equipment, for use in the hospital, as are ordinarily furnished by such hospital for the care and treatment of inpatients; and

(3) such other diagnostic or therapeutic items or services, furnished by the hospital or by others under arrangments with them made by the hospital, as are ordinarily furnished to inpatients either by such hospital or by others under such arrangements;

* * *

§ 1395x(v)(1)(A). [Definition of reimbursable "reasonable costs" pursuant to the Medicare Program].

The reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services . . . . In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organizations or established prepayment organizations (which have developed such principles) in computing the amount of payment,

to be made by persons other than the recipients of services, to providers of services on account of services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this subchapter, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this subchapter) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this subchapter will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the methods of determining costs proves to be either inadequate or excessive.

Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982:

(a) Section 1861(v)(1) of the Social Security Act is amended by adding at the end the following new subparagraph:

"(M) Such regulations shall provide that costs respecting care provided by a provider of services, pursuant to an

assurance under title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefor, shall not be allowable as reasonable costs."

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals.

STATEMENT OF THE CASE

A. AS TO MEDICARE REIMBURSEMENT FOR HILL-BURTON FINANCING COSTS.

While a primary thrust of this Petition is the alleged unconstitutionality of Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982, now codified at 42 U.S.C.A. § 1395x(v)(1)(M) (hereinafter "Section 106"), the constitutional dilemma created by Section 106 has its genesis in the Hospital Survey and Construction Act of 1946, 42 U.S.C. § 291c *et seq.*, popularly known as the Hill-Burton Act. Congress, reacting to gross deficiencies in the nation's health care system uncovered by the need for physical examinations of World War II servicemen, enacted a comprehensive plan for upgrading, *inter alia*, the nation's hospitals. Federal capital construction subsidies, primarily for private, not-for-profit hospitals, totalled approximately $4.2 billion between 1946 and 1975. The Hill-Burton Act requires the Secretary[1] to prescribe regulations ensuring that hospitals receiving federal aid provide the indigent needed medical and hospital care. 42 U.S.C. § 291c(e). This requirement was part of the statutory bargain that hospitals agreed to when they accepted Hill-Burton financing. The relevant section of the Hill-Burton Act has never been amended, and the initial implementing regulations of the Secretary, 12 Fed. Reg. 6179 (1947), remained unchanged in relevant part through 1972.

[1]Originally the Secretary of Health, Education and Welfare, now the Secretary of Health and Human Services, referred to hereinafter as "the Secretary."

Petitioner St. James Hospital (hereinafter "St. James") is a short-term, acute care general hospital which received Hill-Burton financial assistance between 1959 and 1967. In return for those funds, St. James made its facility available to the indigent free of charge in accordance with the Hill-Burton Act and the original regulations. Appendix at 3b. Those regulations provided that the required indigent care "may be paid for . . . out of public funds or contributions of individuals and private and charitable organizations . . . or may be contributed at the expense of the hospital itself." *Id.*

The Medicare program, codified as Title XVIII of the Social Security Act at 42 U.S.C. §§ 1395 *et seq.*, was enacted in 1965, long after St. James and hundreds of other hospitals similarly situated had accepted billions in Hill-Burton financial assistance. The purpose of the Medicare program was, and is, to reimburse participating hospitals the reasonable cost of providing health care to the nation's elderly. The Medicare program and its implementing regulations establish detailed procedures for participating hospitals to obtain reimbursement for the many direct and indirect costs involved in patient care. These indirect costs include such obvious expenses of operating the hospital as utilities and staff salaries, as well as more hidden costs, such as depreciation of the facility and its equipment and finance expenses. St. James has participated in the Medicare program from its inception.

St. James' participation in the Medicare program did not affect the access to medical care which had been afforded the indigent since 1959, when the hospital first accepted Hill-Burton assistance. However, years after St. James had accepted Hill-Burton financial aid *and* had agreed to participate in the Medicare program, the Secretary significantly increased the financial burden of the Hill-Burton indigent care requirement. For the twenty-five years between 1946 and 1971 the Secretary consistently interpreted the Hill-Burton obligation to be one of providing access to, but not direct financial responsibility for, the indigent. 12 Fed. Reg. 6179 (1947). In 1972, some six years after St. James and most of the nation's other hospitals became participants in the Medicare program, the Secretary altered the regulations implementing the still

unamended Hill-Burton legislation. These regulations provided, for the first time, that the hospitals themselves must directly pay for the free care accorded the indigent. Specifically, the Secretary required that hospitals receiving Hill-Burton financial assistance absorb the costs of providing uncompensated services to the indigent either (a) at an annual level of not less than 3% of the hospital's total operating costs or 10% of all federal assistance received by the hospital for a period of twenty years; or, (b) by maintaining a certified open door policy of providing free care to all qualifying indigents, also for a period of twenty years. 42 C.F.R. § 53.111(d)(1982). This change in the rules of Hill-Burton financing, which had the effect of greatly reducing the net value of the federal subsidy, led many hospitals to attempt to return the Hill-Burton grant and thereby terminate their participation in the program. The Secretary rebuffed these attempts. R. 1050[2]. Moreover, the Hill-Burton regulations were amended in 1974, to require all Hill-Burton hospitals to participate in Medicare. 42 C.F.R. § 53.113(d)(2)(B)(1982).

Reimbursement under the Medicare program is calculated on a "cost year" basis. That is, at the conclusion of its fiscal year, the hospital submits a final accounting, which purports to reconcile all reimbursement already received by the facility and further amounts due from the Government or refunds owed by the facility. For its 1977 cost year, St. James

[2]St. James, following the administrative review process established by the Secretary, first appealed the denial of reimbursement of Hill-Burton free care costs to the Provider Reimbursement Review Board. St. James' administrative appeal was consolidated by the Board with a similar case before it designated as the Florida Hospital Group Appeal. St. James introduced separate evidence as well as arguments common to all of the parties in the Florida Hospital Group Appeal. In rendering its decision with respect to St. James, the Board adopted its decision in the Florida Hospital Group Appeal. Because the evidence and administrative action appealed in this case with respect to St. James are fully set forth only in the administrative record of the Florida Hospital Group Appeal, a copy of which was filed with the district court and transferred to the Court of Appeals for the Seventh Circuit, citations to the administrative record will be to the Florida Hospital Group Appeal record and will be designated "R. ____."

documented costs of $159,300 which it incurred in providing the indigent care required by the 1972 regulation. Maintaining that these costs were no different than any other expenses of obtaining financing, St. James included this sum in its 1977 cost report and asked for reimbursement consistent with the percentage of its services represented by Medicare patients. Appendix at 3b-4b. This request was denied by the Secretary, in the person of the Provider Reimbursement Review Board.

After exhausting its administrative remedies, St. James filed suit against the Secretary in the Northern District of Illinois. Upon cross-motions for summary judgment, United States District Judge Leighton found for St. James, concluding that indigent care mandated by the Hill-Burton regulations was not charity, but rather was no different than any other financing cost and was thus reimbursable under Medicare program formula. Appendix at 11b-13b.

Judge Leighton relied, in part, upon two Fifth Circuit cases, *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir.), *cert. denied*, 454 U.S. 940 (1981), and *Rapides General Hospital v. Matthews*, 435 F. Supp. 384 (W.D. La. 1977), *vacated and remanded on other grounds*, No. 77-3125 (5th Cir., October 23, 1978) (unpublished order). Both of these decisions confirmed that Hill-Burton free care expenses were no more than financing costs imposed by the lender/grantor, in this case, the federal Government. Many district courts agreed with the reasoning of *Presbyterian Hospital*,[3] albeit a few did not.[4] All of the cases lost by the Secretary were appealed. While the appeal process was ongoing in several circuits, the Secretary prevailed upon the House Committee on Ways and Means to insert Section 106 into the omnibus Tax Equity and Fiscal

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[3]*Iredell Memorial Hospital v. Schweiker*, 535 F. Supp. 795 (W.D.N.C. 1982); *Johnson County Memorial Hospital v. Schweiker*, 527 F. Supp. 1134 (S.D. Ind. 1981); *Metropolitan Medical Center v. Harris*, 524 F. Supp. 630 (D. Minn. 1981); *Memorial Hospital et al. v. Schweiker*, Civil No. 80-67 (M.D. Fla., Oct. 20, 1981).

[4]*St. Mary, Etc. v. Dept. of Health & Human Serv.*, 531 F. Supp. 419 (N.D. Ill. 1982); *Harper-Grace Hospitals v. Schweiker*, Civil No. 80-72082 (E.D. Mich., April 1, 1981).

Responsibility Act of 1982, quoted at pp. 4-5 of this Petition. At the time of the Act's effective date, there were at least five cases before the Courts of Appeals of the 4th, 6th, 7th, 8th and 11th Circuits.[5] At that time, the Seventh Circuit had not reached a decision herein. Both St. James and the Secretary filed supplemental briefs addressing the constitutionality of Section 106. It is from the decision of the Seventh Circuit confirming the constitutionality of Section 106 and denying reimbursement for Hill-Burton costs that St. James petitions for certiorari.[6]

B. AS TO MEDICARE REIMBURSEMENT FOR PATIENT TELEPHONES.

St. James provides all of its patients (private, Medicare and indigent) with a bedside telephone as part of their basic care. It is used by physicians and hospital personnel for medical purposes and by patients for their personal use and for communicating with hospital personnel. The multiplicity of uses for the bedside telephone is uncontradicted by the Secretary. R. 695-721, 909-921. The Medicare program requires the Secretary to reimburse hospitals for reasonable costs incurred in providing "therapeutic items or services . . . as are ordinarily furnished to inpatients . . . by such hospital . . . ." 42 U.S.C. § 1395x(b)(3). St. James requested Medicare program reimbursement for providing these telephone services in the same manner that other therapeutic medical costs are paid for. Reimbursement was denied and St. James challenged the refusal by appealing to the Provider Reimbursement Review Board. The Board agreed that St. James had demonstrated that patient telephones have therapeutic value. Appendix at 5b-6b. Despite this factual finding, however, the Board concluded it was bound to enforce the regulation prohibiting reimbursement

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[5] *Memorial Hospital et al. v. Heckler*, No. 81-6230 (11th Cir., June 6, 1983); *Iredell Memorial Hospital v. Schweiker*, 699 F.2d 196 (4th Cir. 1983); *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808 (6th Cir. 1982); the present case; *Metropolitan Medical Center v. Harris*, 693 F.2d 775 (8th Cir. 1982).

[6] A Petition for Certiorari to the Court of Appeals for the Seventh Circuit has already been filed in *Johnson County Memorial Hospital v. Heckler*, 51 U.S.L.W. 3827 (U.S., May 17, 1983) (No. 82-1805).

for patient telephones, 42 C.F.R. § 405.310(j)(1982). Appendix at 6b. The Board's finding of the bedside telephone's measurable therapeutic value was based upon voluminous and uncontested testimony. Appendix at 5b-6b. The Secretary, acting through the Administrator of the Health Care Financing Administration, did not disturb the Board's factual finding of therapeutic value in affirming the legal conclusion denying reimbursement.

St. James combined its challenge to the denial of reimbursement for bedside telephone costs with the Hill-Burton action. Upon cross-motions for summary judgment, United States District Judge Leighton found that the Secretary's action in declaring telephone costs nonreimbursable was not supported by substantial evidence. Furthermore, the regulation at issue was held to be a clearly erroneous interpretation of Congressional intent. Appendix at 19b-21b. Judge Leighton was of the opinion that because of the unrebutted proof that bedside telephones are an ordinary and therapeutic medical service, the Secretary committed a serious error of judgment in construing and applying 42 C.F.R. § 405.310(j)(1982), thus rendering the Secretary's action arbitrary and capricious. On appeal to the United States Court of Appeals for the Seventh Circuit, the court dismissed the Secretary's procedural objections to reaching the merits of the telephone issue. However, the court concluded that St. James had failed to demonstrate that the Secretary had abused her discretion in determining that bedside telephones are not therapeutic services ordinarily supplied patients. Appendix at 18a.

St. James contends that the Secretary has acted in contravention of the Medicare Act by refusing to reimburse it for a service that the Provider Reimbursement Review Board has found ordinary and therapeutic.

REASONS FOR GRANTING THE WRIT

I.

THE DECISION OF THE COURT OF APPEALS CONFLICTS WITH SEVERAL DECISIONS OF THIS COURT.

A. Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982 is an Impermissible Attempt by Congress to Adjuticate a Monetary Decision in Favor of the Government.

Article III of the Constitution vests "the judicial power of the United States" in the federal courts, not Congress. It has long been the position of this Court that Congress may not determine the outcome of a case on appeal, at least where a monetary judgment in favor of the Government is the result. *United States v. Klein*, 80 U.S. (13 Wall.) 128 (1872). Here, St. James had been granted a substantial monetary judgment by the district court, as had scores of other hospitals in diverse districts.[7] These judgments were for millions in costs already incurred serving Medicare patients during the 1970's. After the Secretary had appealed these judgments, but before a single court of appeals had agreed with the Government, Congress, by enacting Section 106, attempted to decide in the Government's favor each case then *sub judice*. This usurped the power of the courts of appeals to reach the merits of the Hill-Burton financing issue in as blatant and direct a violation of the separation of powers doctrine set out in *Klein* as can be imagined.

Klein concerned an attempt by the Reconstruction Congress to thwart compensation of those who had perhaps sympathized with the Confederacy. Plaintiff Klein was the administrator of the estate of one Wilson, whose cotton had been seized and sold by Union agents during the Civil War. Klein sued the Government in the Court of Claims for the sale proceeds, a cause of action bottomed upon the Abandoned Property Collection Act of 1863, which granted a cause of action to noncombatants who proved they had "never given any aid or comfort to the present rebellion."[8] Initially Wilson was found to have been loyal in fact and Klein was awarded $125,300. *Wilson v.*

[7]For example, the Florida Hospital Group Appeal, *Memorial Hospital, et al., v. Schweiker*, Civil No. 80-67 (M.D. Fla., Oct. 20, 1981), concerned sixty-one hospitals in Florida and one in the District of Columbia.

[8]Ch. 120, § 3, 12 Stat. 820 (1863).

United States, 4 Ct. Cl. 559, 567 (1868), *aff'd sub nom. United States v. Klein*, 80 U.S. (13 Wall.) 128 (1872). After noting an appeal to this Court, the Government moved the Court of Claims to "open up" the *Klein* judgment because of newly discovered evidence indicating Wilson's disloyalty in fact. Because of President Johnson's pardon of 1868, the Court of Claims again found against the United States. *Id.* at 141. The Government renewed its appeal to this Court. While the appeal was pending, the radical Republicans prevailed upon Congress to pass legislation requiring the Court of Claims to treat a presidential pardon as conclusive evidence of disloyalty and to dismiss claims such as Klein's summarily for lack of jurisdiction. Act of July 12, 1870, 16 Stat. 235 (1870). This unvarnished attempt to direct a decision of this Court, after a trial court judgment against the Government, was found unconstitutional. No less an invasion of the judicial sphere is attempted by Section 106, which purports to revoke several trial court monetary judgments against the Government.

Petitioner St. James stresses that the monetary judgment granted by the district court may not be erased by broad application of the "changed law rule" requiring appellate level courts to apply only statutes in force at the time an appeal is decided. *United States v. Schooner Peggy*, 5 U.S. (1 Cranch) 103 (1801). In *Klein*, Mr. Chief Justice Chase, speaking for the Court, carved out what might be considered an exception to the changed law rule, *i.e.*, Congressional destruction of a monetary judgment rendered against the Government is inconsistent with the Constitution.

> What is this but to prescribe a rule for the decision of a cause in a particular way? In the case before us, the court of claims has rendered judgment for the claimant and an appeal has been taken to this court. We are directed to dismiss the appeal, if we find that the judgment must be affirmed, because of a pardon granted to the intestate of the claimants. Can we do so without allowing one party to the controversy to decide it in its own favor? Can we do so without allowing that the legislature may prescribe rules of decision to the judicial department of the government in cases pending before it?

> We think not; and thus thinking, we do not at all question what was decided in the case of *Pennsylvania v. Wheeling Bridge Company,* 18 How. 429, 15 L. ed. 436. . . .
>
> We must think that Congress has inadvertently passed the limit which separates the legislative from the judicial power.

United States v. Klein, 80 U.S. (13 Wall.) at 146-47. The parallel between the Reconstruction Congress' dissatisfaction with the perhaps unintended judgments pursuant to the Abandoned Properties Act is indistinguishable from the 1982 Congress' unhappiness with certain judgments interpreting the Medicare legislation of 1965. Section 106 is far more than a minor repair of the Medicare program; its close correspondence with legislation attempted by the Reconstruction Congress renders the decision below utterly irreconcilable with *Klein*. Section 106 was tacked to the Tax Equity and Fiscal Responsibility Act of 1982 during frenzied budget cutting and legislative compromise. While this may be an apt description of much of the democratic process, the less than contemplative Congressional *reaction* to judicial decisions in the post-Civil War period is comparable to the admitted reaction to the developing case law attempted in Section 106 of the Tax Equity and Fiscal Responsibility Act of 1982.[9]

In its enactment of Section 106, Congress made no attempt to mask its intention "to prescribe a rule for the decision of a cause in a particular way . . . ." *Id.* at 146. The implementation of the Section 106 "rule of law" by the court below is in direct and indistinguishable conflict with this Court's decision

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[9]The Court of Appeals for the Seventh Circuit reversed the judgment in St. James' favor, specifically finding Section 106 constitutional, without even a passing reference to *Klein* and progeny, despite full briefing. To the extent, if any, that the court below based its decision not on Section 106, but upon a rejection of the statutory interpretation that is the essence of the district court's decision, the Seventh Circuit noted that it is in direct conflict with the Fifth Circuit decision of *Presbyterian Hospital of Dallas v. Harris,* 638 F.2d 1381 (5th Cir.), *cert. denied,* 454 U.S. 940 (1981). Appendix at 14a-15a. See pp. 18-20, *infra*.

in *Klein*, and for that reason alone, certiorari should be granted.

Klein is not a judicial curiosity engendered by the unique circumstances of the Reconstruction Era. Rather, succeeding Courts have reaffirmed the proscription against Congressional intrusion into the appellate process, where the legislature is attempting to decide a cause in its monetary favor.[10] The most recent opinion of this Court in conflict with the decision below is *United States v. Sioux Nation of Indians*, 448 U.S. 371 (1980), which probably contains the most searching examination of *Klein*. Justice Blackman distinguished *Klein* from the extraordinary set of facts presented by *Sioux Nation*, but in doing so placed *Klein* squarely at odds with the decision of the court of appeals below. That is, the legislation at issue in *Klein* was found to be unconstitutional in two respects, the first of which goes to the heart of St. James' present Petition:

> First, it prescribed a rule of decision in a case pending before the courts, and did so in a manner that required the courts to decide a controversy in the Government's favor.

Id. at 404.

When Section 106 was enacted there was an unmistakable tide running in favor of the hospitals, both at the trial and appellate levels. This case was pending before the Seventh Circuit, and Section 106 required that court "to decide a controversy in the Government's favor." *Id.* The unconstitutional conflict between the circuit court's view of Section 106 and *Klein*, as explained in *Sioux Nation*, is inescapable.

> [W]hen Congress regulates functions of the judiciary in a *pending* case it walks the line between judicial and legislative authority, and exceeds that line if it sets aside a judgment or orders retrial of a previously adjudicated issue. *United States v. Klein, supra*, at 145 . . . .

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[10] *See, e.g., McCullough v. Virginia*, 172 U.S. 102 (1898); *Hodges v. Snyder*, 261 U.S. 600 (1925); *Pope v. United States*, 323 U.S. 1 (1944).

Id. at 430 (dissent of Mr. Justice Rehnquist)(emphasis supplied in text).

Section 106, accepted by the court below, is irreconcilable with the consistent principle first espoused in *Klein*, and reaffirmed most recently in *Sioux Nation*. The decision should be reviewed to bring it into conformity with unmistakable precedents of this Court.

B. *Section 106 Abrogates Contractual Obligations of the United States in Violation of This Court's Decision in* Lynch v. United States.

In *Lynch v. United States*, 292 U.S. 571 (1934), a unanimous Court sustained the right of beneficiaries of War Risk Insurance policies, which had been issued by the Government, to recover on those policies despite the existence of Section 17 of the Economy Act of 1933, 48 Stat. 8 (then codified at 38 U.S.C. § 717), which provided that "[a]ll laws granting or pertaining to yearly renewable term insurance are hereby repealed . . . ." The Court held that the statute violated the Fifth Amendment due process clause as a taking of property without just compensation. In support of its conclusion, the Court stated:

> The Fifth Amendment commands that property be not taken without making just compensation. Valid contracts are property, whether the obligor be a private individual, a municipality, a state or the United States. Rights against the United States arising out of a contract with it are protected by the Fifth Amendment.

292 U.S. at 579. The Court went on to state that

> Congress [is] without power to reduce expenditures by abrogating contractual obligations of the United States. To abrograte contracts, in the attempt to lessen government expenditure, would be not the practice of economy, but an act of repudiation. "The United States are as much bound by their contracts as are individuals. If they repudiate their obligations, it is as much repudiation, with all the wrong and reproach that term implies, as it would be if the repudiator had been a State or a municipality or a citizen."

Id. at 580 (*quoting from The Sinking Fund Cases*, 99 U.S. 700, 719 (1879)). The vitality of the holding in *Lynch* is evidenced by numerous subsequent cases dealing with the constitutionality of state and federal legislation retroactively repudiating contractual rights flowing from the government to individuals.[11]

When petitioner became a participating hospital in the Medicare program in 1965, it agreed to provide medical care for elderly patients, receiving in exchange as consideration the reasonable and necessary costs incurred in providing those services. This contractual relationship continues in effect to the present. Congress may repudiate the reimbursement of all or a portion of those costs only under the three limited circumstances discussed in *Lynch*.[12] Section 106 fits none of the tests.

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[11]*See, e.g., United States v. Larionoff*, 431 U.S. 864, 879 (1977) (action by re-enlisted members of U.S. Navy for bonuses under the terms of the Variable Reenlistment Bonus Program); *United States Trust Company of New York v. New Jersey*, 431 U.S. 1, 26 (1977); *Thorpe v. Housing Authority of City of Durham*, 393 U.S. 268, 278-9 (1969); *Blanchette v. Connecticut General Insurance Corps*, 419 U.S. 102, 134-5 (1974).

[12]The three factors to be assessed are: (1) the nature and strength of the public interest served by the statute; (2) the extent to which the statute modifies or abrogates the asserted pre-enactment right; and (3) the right which the statute alters. A governmental need to economize does not create a sufficiently strong public interest to justify repudiating otherwise valid financial obligations of the government. *Lynch v. United States*, 292 U.S. at 580. Significantly, Section 106 is part of Title I of The Tax Equity and Fiscal Responsibility Act of 1982, which is entitled "Provisions Relating to Savings in Health and Income Security Programs." Section 106 would retroactively eliminate in its entirety petitioner's preexisting contractual right to Hill-Burton indigent care cost reimbursement under the Medicare Act. Moreover, petitioner, like other participating hospitals, has set its rate schedules for all of its non-indigent patients in reliance on and expectation of Medicare reimbursement for Hill-Burton indigent care costs.

Retroactive abrogation of the Government's obligation to reimburse Hill-Burton indigent care costs leaves the Medicare portion of those costs unfunded to the Medicare providers. In practical effect, the Government attempts in Section 106 to benefit the coffers of the U.S. Treasury at the expense of future non-Medicare patients who would inevitably bear the burden of past, present and future indigent care costs for which the Government now reneges. Such a result is constitutionally impermissible. *See Allied Structural Steel Co. v. Spannaus,* 438 U.S. 234, 250, *reh'g. denied,* 439 U.S. 886 (1978).

C. *The Decision of the Court of Appeals Would Require St. James to Operate at a Loss, Which Constitutes an Unconstitutional Taking of Its Property.*

This Court has repeatedly held that a government may not require one to operate his business at a loss. This principle receives perhaps its most complete explanation in the context of railroad franchises:

> The usual permissive charter of a railroad company does not give rise to any obligation on the part of the company to operate its road at a loss . . . . To compel it to go on at a loss or to give up the salvage value would be to take its property without the just compensation which is a part of due process of law.

Railroad Commission v. Eastern Texas R. Co., 264 U.S. 79, 85 (1924). Similarly, once such a business is operating under a public franchise, regulation which would thereafter require operation at a loss is also unconstitutional. *Russell v. Sebastian,* 233 U.S. 195 (1914).

Application of this principle to a hospital such as St. James is a three step process. First, present Hill-Burton regulations, promulgated long after St. James became a participant in the program, require the hospital both to participate in Medicare and to provide a formula-based minimum of free care to the indigent. 42 C.F.R. § 53.113 (1982). Petitioner may not withdraw from the Hill-Burton program.[13] Second, Section 106, reversing substantial case law to the contrary, prohibits

[13]See text preceding note 2, *supra* p. 7.

the Medicare program from contributing its pro rata patient share of the free care financing costs, which in this case total 26% of $159,30 or $42,000. Third, St. James is prohibited, by both law[14] and regulation,[15] from looking to its non-Medicare, non-indigent patient population for payment of the $42,000. Finally, philanthropy, the only remaining source for the $42,000, has proven inadequate. R. 1838. St. James and all other hospitals receiving Hill-Burton assistance, some of which have Medicare utilization ratios in the 80% range (R. 1632), thus have no means of paying for the Hill-Burton free care mandated by regulation; they *must* operate at a loss. St. James thus has no way out of the dilemma created by Section 106 and sanctioned by the court below; *both* Medicare *and* private patients are prohibited from contributing to the Medicare share of indigent care while all patients benefit from the Hill-Burton subsidized physical plant.

St. James is by definition a non-profit institution. The Court below gives it the option of operating at a loss or closing its doors. This is in direct conflict with *Railroad Commission* and *Russell*. Certiorari should be granted to examine the inconsistency between those decisions of this Court and the decision below.

II.

TO THE EXTENT THE DECISION BELOW DOES NOT RELY UPON SECTION 106, IT DIRECTLY CONFLICTS WITH THE COURT OF APPEALS FOR THE FIFTH CIRCUIT.

The only appellate decision on Hill-Burton financing preceding enactment of Section 106, *Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381 (5th Cir.), *cert. denied*, 454 U.S. 940 (1981), held Hill-Burton costs reimbursable. In all likelihood, it was that decision and the subsequent series of trial court decisions in favor of providers on the Hill-Burton issue[16] which caused the Secretary to initiate passage of

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[14]42 U.S.C. § 1395x(v)(1)(A).

[15]42 C.F.R. § 405.451(1982).

[16]Those cases are cited in note 3, *supra*, p. 8.

Section 106. Presbyterian Hospital of Dallas, a Medicare program participant, had received a Hill-Burton interest subsidy on its loans and, as a result of the 1972 regulation changes, was thus required to provide a formula-defined amount of free care to the indigent. It sought partial, pro rata reimbursement of this financing cost from the Medicare program, but was refused by the Secretary.

A unanimous Fifth Circuit concluded that Hill-Burton financing costs, in the form of free care mandated by regulation, are no different from other indirect hospital expenses, and were thus the proper subject of reimbursement.

> Although the provision of free care pursuant to this obligation inures to the direct benefit of indigents rather than to medicare patients, it indirectly benefits medicare patients by qualifying the Hospital for federal interest subsidies on construction and modernization projects which are ultimately used by medicare patients. . . .
>
> . . .The fact that such expenses also benefited indigent persons who were not medicare beneficiaries is irrelevant to the determinative issue: whether the expenses were a reasonable cost incurred in the provision of services to medicare patients. We conclude, therefore, that the free care expenses incurred by the Hospital in connection with its obligations under the Hill-Burton Act were reasonable costs of providing care to all of its patients, including medicare patients, and are consequently reimbursable to the extent that this indirect cost benefited medicare patients.

Id. at 1386-87 (footnote omitted).

This analysis, relied upon by petitioner below, was specifically and expressly rejected by the Seventh Circuit. Appendix at 14a-15a. In fact, *Presbyterian Hospital of Dallas* was disparaged as a hospital administrator's "dream" and "wild expectation" and as being without a "scintilla" of factual foundation. Appendix at 15a. While it appears that the court below ultimately bottomed its decision on a specific finding of the constitutionality of Section 106 (Appendix at 19a), to the extent the circuit court's decision represents a rejection of peti-

tioner's underlying theory of reimbursement, its conflict with the Fifth Circuit is irreconcilable.

The split in the circuits is further demonstrated by *Metropolitan Medical Center v. Harris*, 693 F.2d 775 (8th Cir. 1982) and *Iredell Memorial Hospital v. Schweiker*, 699 F.2d 196 (4th Cir. 1983), both of which reversed district court opinions granting Hill-Burton reimbursement. *Iredell Memorial Hospital* did not discuss Section 106 of the Tax Equity and Fiscal Responsibility Act. *Metropolitan Medical Center* noted the recent enactment of that bill, but chose not to rely on it "to avoid possible litigation involving the question of whether this amendment to the Medicare Act can be constitutionally applied . . . ." 693 F.2d at 778n.2. The federal judicial policy of avoiding adjudication of constitutional issues whenever possible suggests a preliminary analysis of the merits of Hill-Burton reimbursement, an issue on which the opinions of the various courts of appeals are irreconcilably in conflict.

St. James makes this observation in order to make it clear that certiorari is appropriate no matter which basis for the decision below this Court should deem controlling. If the decision below represents an unvarnished application of Section 106, the conflicts with *Klein, Lynch and Railroad Commission* are unavoidable. Conversly, to the extent the decision goes behind Section 106 to address the specific reimbursement issues, it represents an express conflict with the Fifth Circuit.

III.

THE DEFERENCE ACCORDED THE SECRETARY'S REGULATION PERTAINING TO REIMBURSEMENT FOR BEDSIDE PATIENT TELEPHONES IN THE OPINION BELOW IS INCONSISTENT WITH SEVERAL RECENT DECISIONS OF THIS COURT.

St. James Hospital routinely supplies bedside telephones to all of its patients, and seeks Medicare program reimbursement for the pro rata cost of supplying these telephones to Medicare beneficiaries. Although the Medicare program requires reimbursement of all therapeutic hospital services regularly provided to patients, 42 U.S.C. § 1395x(b)(3), and bedside telephones have proven therapeutic value (A. 56,

146-156), the Secretary has promulgated a regulation conclusively presuming telephones to be non-therapeutic and thus not subject to reimbursement. 42 C.F.R. § 405.310(j)(1982). The court below, in conflict with this Court's decisions in *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974), *Vlandis v. Kline*, 412 U.S. 441 (1973), and *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971), sanctioned a regulation which is both arbitrary and an irrebutable presumption inconsistent with established fact.

A. *The Secretary Does Not Have Discretion to Promulgate Rules which Contravene Established Fact.*

While this Court has repeatedly ruled that the judiciary is not to second-guess Executive branch administrators, neither are the courts bound by interpretive regulations, such as 42 C.F.R. § 405.310(j)(1982), where the agency's determination can be shown to be arbitrary and capricious or an abuse of discretion. *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944). The Medicare statute left definition of "personal comfort items" to the Secretary. 42 U.S.C. § 1395y(a)(3). The definition at issue was first promulgated in 1966. 31 Fed. Reg. 13534 (1966). Utilizing the so-called benefits exemption of the Administrative Procedure Act, 5 U.S.C. § 553(a)(2), the Secretary simply promulgated the rule, without opportunity for debate or criticism by the public or health care providers. Thus, the court below did not have benefit of any official explanation or rationale for the regulation. The only medical evidence adduced in this case, which the district court and the Secretary's own Provider Reimbursement Review Board found convincing, was that bedside telephones *have* measurable therapeutic value. It is the position of St. James that the regulation found acceptable by the court below cannot withstand examination under the principles announced in *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402 (1971), and other decisions of this Court addressing the foundation for Executive action.

The circuit court recognized that the Administrative Procedure Act requires that the Secretary's rule be neither arbitrary, capricious, nor an abuse of discretion. In order to make such a finding, the reviewing court must "consider whether

the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Id.* at 416. Because the Secretary adduced no medical evidence whatever in support of the blanket exclusion (Appendix at 16b), it was impossible for the court below to make even the most cursory examination of the statutory underpinning for the regulation prohibiting reimbursement for bedside patient telephones. In reversing the district court, the circuit court gave judicial approval to a decision for which "a consideration of the relevant factors" in favor of the Secretary's interpretation was impossible.

When this Court ordered a remand in *Overton Park,* it indicated that further explanation would be required from the agency promulgating the rule. Only with this explanation could there be meaningful judicial review. *Id.* at 420. The action of the Secretary here is even more egregious: the original rule was promulgated upon no administrative record and the Provider Reimbursement Review Board accepted the hospitals' proof of the regulation's clear inconsistency with established fact. Even in "benefits exemption" cases, Congress does not grant the bureaucracy the unfettered discretion the Secretary deems appropriate. More to the point, it is improper for reviewing courts to ratify agency interpretive rulemaking when the administrative record is utterly devoid of any foundation for the agency's action. Even if the proscription against bedside telephone reimbursement was valid when made, *Overton Park* requires the Secretary to explain that regulation when proof of its arbitrariness and inconsistency with the enabling legislation is later provided. Certiorari should be granted in order to allow a correction of this clear inconsistency with the procedures required by *Citizens to Preserve Overton Park v. Volpe.*

B. *The Court Of Appeals, in Conflict With* Cleveland Board of Education v. LaFleur, *Has Sanctioned an Irrebutable Conclusion of Medical Fact.*

The circuit court, in direct conflict with *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974), has sanctioned the Secretary's irrebutable conclusion of medical fact. This Court's decision in *Cleveland Board of Education v. LaFleur* confirms that the Executive branch may not irrebutably presume that a situation or circumstance represents immutable medical fact. The Medicare Act specifically provides that the Secretary is to promulgate rules to determine what reimbursement is due providers generally, 42 U.S.C. § 1395hh, and specifically with regard to defining "reasonable cost." 42 U.S.C. § 1395x(v)(1)(A). The rule at issue, defining whether bedside telephone service is or is not medically beneficial, has the force of law, provided "it be not in conflict with express statutory provision." *Maryland Casualty Co. v. United States*, 251 U.S. 342, 349 (1920). Such legislative rulemaking must comport with the due process clause of the Fifth Amendment. Because the regulation creates an irrebutable medical presumption, it cannot be distinguished from other legislative medical presumptions found constitutionally infirm by this Court. *Cleveland Board of Education v. LaFleur*, 414 U.S. 632 (1974).[17]

The Secretary's definition of personal comfort items is undeniably reviewable. Appendix at 18a. While it may have been a reasonable exercise of agency discretion at the time of promulgation, the irrebutable presumption of medical "fact" that bedside telephones are not therapeutic is always subject to contrary proof. St. James stresses that the Provider Reimbursement Review Board found measurable therapeutic value and stated that bedside telephone costs should be reimbursed. Appendix at 5b, 14b-15b. The Board, however, declared itself to be bound by the Secretary's irrebutable presumption to the contrary. This regulatory tactic, sanctioned but not discussed by the court below, cannot be squared with the holding of this Court.

> As the Court noted last Term in Vlandis v. Kline . . . "permanent irrebutable presumptions have long been disfavored under the Due Process Clauses of the Fifth and Fourteenth Amendments."

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[17] *See also, Vlandis v. Kline*, 412 U.S. 441 (1973)(statutory irrebutable presumption as to domicile violative of due process).

Cleveland Board of Education v. LaFleur, 414 U.S. at 644. A regulation declaring that bedside telephones cannot have medical value, no matter what proof is presented, is no less constitutionally infirm than a school board's inflexible regulation as to when a pregnant teacher is no longer fit for classroom duties. *Id.* at 644-46. St. James, with the other sixty-two hospitals in the Florida Hospital Group Appeal, produced a record in excess of two thousand pages in successfully arguing to the Provider Reimbursement Review Board the medical fact that telephones *are* therapeutic. It is the position of the Secretary, sanctioned by the court below, that no matter how persuasive the proof adduced by St. James, bedside telephones are forever to be classed non-therapeutic. It is important to note that the Secretary simply affirmed the Board's conclusion that it was procedurally bound by the decade-old regulation. No explanation of or rationale for the regulation has appeared on the record in any form at any time. This Court has repeatedly held that "a statute creating a presumption which operates to deny a fair opportunity to rebut it violates the due process clause of the Fourteenth Amendment." *Heiner v. Donnan*, 285 U.S. 312, 329 (1932).

Congress delegated to the Secretary authority to decide whether bedside telephones are solely for "personal comfort" and thus the subject of reimbursement. Congress did not, and could not pursuant to the authorities just discussed, leave to the Secretary the power to decide a medical question without affording those affected the opportunity to rebut such a finding. The Secretary, in clear conflict with *Cleveland Board of Education v. LaFleur*, had granted himself medical omniscience. Certiorari should be granted to review that action.

CONCLUSION

For these reasons, a writ of certiorari should issue to review the judgment and opinion of the Court of Appeals for the Seventh Circuit.

Respectfully submitted,

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June 30, 1982

UNITED STATES COURT OF APPEALS

FOR THE SEVENTH CIRCUIT

No. 82-1237

SAINT MARY OF NAZARETH HOSPITAL CENTER,
Plaintiff-Appellant,

v.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,
Defendants-Appellees.

No. 82-1253

ST. JAMES HOSPITAL,
Plaintiff-Appellee,

v.

RICHARD S. SCHWEIKER, SECRETARY OF
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant-Appellant.

Argued October 27, 1982 Decided February 1, 1983

Before Bauer and Coffey, Circuit Judges, and Wisdom, Senior Circuit Judge.*

COFFEY, Circuit Judge. This appeal is the consolidation of two conflicting district court decisions challenging the payment of Medicare funds to hospitals in reimbursement of Medicare's percentage of the costs incurred by hospitals in rendering medical care to indigents in fulfillment of the hospitals' obligations to the federal government as recipients of Hill-Burton funds. In *Saint Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 531 F. Supp. 419 (N.D. Ill. 1981), the district court granted the defendant's motion for summary judgment on the grounds that the plaintiff hospital was not entitled to Medicare reimbursement for the percentage allocated to Medicare of the free care the hospital provided to indigents in fulfillment of its obligations under the Hill-Burton Act, while in the *St. James Hospital v. Harris*[1] case, 535 F. Supp. 751 (N.D. Ill. 1981), the court granted the plaintiff hospital's motion for summary judgment on the grounds that the hospital was entitled to such reimbursement. The *St. James Hospital* court also found that a bedside telephone furnished by a hospital was not a "personal comfort item" and thus the Secretary erred when he ruled that 42 C.F.R. § 405.310(j)[2] controlled and prohibited reimbursement

*The Honorable John Minor Wisdom, Senior Circuit Judge of the United States Court of Appeals for the Fifth Circuit, is sitting by designation.

[1]In a footnote, the court noted: "Patricia Roberts Harris, who is here sued only in her official capacity, has been succeeded in office by Richard S. Schweiker. However, for literary reasons, there having been no motion for substitution, the court has treated the case as against the Secretary during whose term of office this controversy arose. Under the circumstances, by operation of law, the substitution is automatic; and the judgment in this case is against the current incumbent who becomes the named defendant. *See Bracco v. Lackner*, 462 F.Supp. 436 (N.D. Cal. 1978); Fed.R.Civ.P. Rule 25(d), 28 U.S.C.A."

435 F. Supp. at 765 n.1. For the purpose of this appeal, the current Secretary has been substituted for Ms. Harris.

[2]42 C.F.R. § 405.310(j) states: "no payment may be made for any expenses incurred for the following items or services: (j) Personal comfort items and services (for example a television set, or telephone service, etc.)."

of the costs the hospital incurred in furnishing bedside telephones to Medicare patients. We affirm *Saint Mary of Nazareth Hospital v. Dept. of Health and Human Services*, and reverse *St. James Hospital v. Harris*.

Saint Mary of Nazareth Hospital, located in Chicago, Illinois, is a 490 bed acute care general hospital and was rated qualified by the Secretary of the United States Department of Health and Human Services as a provider of medical services under the provisions of the Social Security Act relating to the Medicare program. 42 U.S.C. § 1395 *et seq.* (1976). Qualified hospital providers such as Saint Mary's are entitled to reimbursement for the reasonable costs of providing medical treatment to those qualified for Medicare benefits under the Social Security Act, as defined in the Secretary's regulations. 42 U.S.C. §§ 1395f(b), 1395x(v)(1)(A) (1976). A private health insurance organization (Blue Cross/Blue Shield) acting as a "fiscal intermediary"[3] initially analyzes the Medicare cost reports submitted by hospitals, and after review of these cost reports, allows or disallows the costs claimed to have been incurred by the hospitals and reimburses the health care providers for the "reasonable cost" of the services rendered to Medicare beneficiaries. 42 C.F.R. § 405.401(c) In 1974 Saint Mary's

[3]Medicare providers are usually reimbursed for the reasonable cost of care the hospitals render to Medicare beneficiaries by private organizations acting as "fiscal intermediaries" pursuant to contracts with the Secretary. 42 U.S.C. § 1395h. It is the fiscal intermediary's responsibility to ascertain the amount of reimbursable "reasonable cost" in accordance with regulations promulgated by the Secretary. At the end of the hospitals' fiscal years, the participating hospitals must submit cost reports to the fiscal intermediary documenting the "reasonable costs" provided to Medicare beneficiaries. 42 C.F.R. § 405.406(b). As the liaison between the government and the provider hospitals the fiscal intermediary determines whether the hospitals are acting in a fiscally responsible manner and undertakes an analysis of the cost reports. 42 C.F.R. § 1803. After reimbursing the provider hospitals for the reasonable costs of the medical treatment the hospitals rendered to Medicare beneficiaries pursuant to the Secretary's regulations, the fiscal intermediary is itself reimbursed by the government.

entered into a contract with the federal government and received funds under the Hill-Burton Act to construct its present facility.[4]

The Secretary's Regulations implementing the Hill-Burton Act require that, in repayment of the grant, participating hospitals provide a percentage of free medical care and services to indigent persons residing in the hospitals' "territorial area," 42 U.S.C. § 291c(e), based on one of the following three formulas: not less than the lesser of (1) 10% of all federal assistance received under the Hill-Burton Act; or (2) 3% of the hospital's net operating costs. As a third alternative, the hospital could elect to adopt the "open door" policy and provide care to all local indigents who are admitted to the hospital and in need of medical care or treatment. 42 C.F.R. § 53.111. Saint Mary's elected to provide uncompensated care under the 10% formula and for the fiscal years 1977 and 1978 Saint Mary's provided free care to indigents amounting to $120,656 and $180,065 respectively. Saint Mary's then sought to have the Medicare program reimburse the hospital for the costs they incurred in fulfillment of their Hill-Burton obligation to indigents. The fiscal intermediary denied Medicare reimbursement of the "costs" claimed for the rendering of free care to indigents arising out of Saint Mary's Hill-Burton obligation. The Provider Reimbursement Review Board[5] upheld the decision of the fiscal intermediary. Thereafter, the Deputy Administrator of the Health Care Financing Administration acting for and on behalf of the Secretary of the Department of Health and Human Services declined to review the Provider Reimbursement Review Board's finding and thus the Board's administrative decision became final.

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[4]The Hill-Burton Act, 42 U.S.C. § 192 *et seq.*, was passed in 1946 to assist in the construction and modernization of hospitals and to assure adequate hospital services for all. In order for a participating hospital to receive federal funds under the Hill-Burton Act, the hospital must provide "a reasonable volume of services for persons unable to pay therefor." 42 U.S.C. § 291c(e).

[5]The Provider Reimbursement Review Board is empowered to conduct a hearing when a provider is not satisfied with and disputes the decision of a fiscal intermediary, if the total amount in controversy is at least $10,000. 42 U.S.C. § 1395oo.

On May 18, 1981 St. Mary's Hospital brought this action and sought judicial review of the Provider Reimbursement Review Board's decision pursuant to 42 U.S.C. § 1395oo(f). The parties (Saint Mary's Hospital and the Secretary of the Department of Health and Human Services) each filed cross motions for summary judgment and the district court granted the Secretary's motion for summary judgment while denying Saint Mary's motion. In granting the Secretary's motion for summary judgment Judge McGarr ruled that Congress, in adopting the Medicare legislation did not intend to reimburse hospitals with Medicare funds for the expenses they incurred in providing a percentage of free services to indigents in repayment of their contractual financial obligation to the government as recipients of Hill-Burton funds. Agreeing with the rationale of the Provider Reimbursement Review Board, the court found that since the hospital had already received compensation for the free care it rendered to indigents under the Hill-Burton Act, if the federal government was now required to again pay for these free medical services to indigents with Medicare funds, the net result would be to "compensate the [hospital] a second time for those costs which the government has already paid." Citing *Gaston Memorial Hospital v. Blue Cross,* PRRB No. 81-D84 (September 11, 1981). The court recited that it strained the bounds of logical reasoning to believe that Congress would require hospitals to provide a certain amount of free health care to indigents as compensation for receiving federal funds from one program and then reimburse the hospital with federal funds from another program for the obligation it originally incurred in accepting the Hill-Burton federal grant. Thus, the court up held the Provider Reimbursement Review Board's ruling that the cost of providing free care to indigents pursuant to the hospital's Hill-Burton obligations was not a reimbursable expense under the Medicare program.

St. James Hospital, located in Chicago Heights, Illinois, is also a general hospital the Secretary of the United States Department of Health and Human Services found to be qualified as a provider of medical services under the Medicare program and thus entitled to reimbursement for the

"reasonable costs" of providing health care services to qualified Medicare beneficiaries. 42 U.S.C. § 1395 *et seq.* (1976). St. James Hospital also received Hill-Burton grants[6] and elected to participate in the 10% formula for partial repayment of these grants. In 1977, in fulfillment of its Hill-Burton obligation St. James provided free medical care to indigents in the amount of $159,300. St. James' administrator calculated the percentage of the hospital's overall operating expenses as represented by Medicare patients and sought reimbursement from the Medicare program for this percentage of the hospital's cost of providing uncompensated care to indigents. St. James contends that its obligation to perform a percentage of free services to indigents under the Hill-Burton Act was a proper cost arising out of a financial transaction, and was akin to interest on a loan and therefore reimbursable under the Medicare program. The fiscal intermediary, in disallowing reimbursement, ruled that the Hill-Burton obligation to provide a percentage of uncompensated medical care to indigents represented "charity allowances" and thus had "no relationship to beneficiaries of the health insurance program [Medicare] and are not allowable costs." 42 C.F.R. § 405.420(g). The Provider Reimbursement Review Board agreed with the findings of the fiscal intermediary that the cost of providing free care to indigents was a "charity allowance," and Congress never intended to allow participating hospitals to "charge back" this "obligated charity cost" to the Medicare program.

During the same 1977 fiscal year, St. James Hospital decided to furnish bedside telephones to all hospital patients, including Medicare recipients. In their annual report to the fiscal intermediary and in order to comply with the Secretary's regulations St. James entered the cost of this "personal comfort item" on worksheet A-8 of the 1977 Medicare Costs Report. The effect of this worksheet (A-8) entry acted as a "self-disallowance" of the overall patient telephone costs ($17,000) and thus the question of the telephone costs was not presented to the fiscal intermediary for review. St. James, at a later

[6]St. James used these funds to modernize its existing facility and to construct new facilities.

date, reconsidered this telephone cost reporting technique of "self-disallowance" and raised the issue and sought reimbursement for the cost of telephone service for the first time on its appeal to the Provider Reimbursement Review Board (PR Review Board). The PR Review Board consolidated St. James Hospital's appeal with that of a number of Florida hospitals on the issues of the telephone costs reimbursement and the disallowance of the percentage of free indigent care allocated by the hospitals to Medicare.

After a hearing on St. James' claim for patient telephone costs, the Board held that:

> "this Board does not have the authority to rule on coverage issues and is locked into the Regulation that states that the patient telephone is a luxury item.
>
> The Board finds that the controlling Regulations and Program Policy require the exclusion from allowable costs of all costs associated with telephone services and other personal comfort items which are used for the convenience of patients."

When the Board's decision on both questions became final, St. James filed suit in the Northern District of Illinois pursuant to 42 U.S.C. § 1395oo(f) asking for review of the decision of the Provider Reimbursement Review Board, and the parties filed cross motions for summary judgment.

In granting the plaintiff St. James Hospital's motion for summary judgment, Judge Leighton reasoned that the fiscal intermediary and the Board erred as a matter of law when they classified the rendering of a percentage of free medical services pursuant to the Hill-Burton obligation as "charity." The court reasoned that because St. James was obligated under its Hill-Burton grant agreement to provide a percentage of free care to indigents, the free care St. James provided indigents should not be considered as "charity." Moreover, the court further stated that the rendering of free services was "no different than costs which the hospital could have been required to pay as interest on the grants it received under

the Hill-Burton Act." The court ruled that the Hill-Burton obligation of providing free care was not "charity" and that the Secretary's refusal to set aside the fiscal intermediary's disallowance was tantamount to "an abuse of discretion and not in accordance with law."

As to the issue of Medicare's reimbursement of patient telephone costs, the court found the Provider Reimbursement Review Board's decision that they were without jurisdiction to rule on the claim resulted in a "hypertechnical construction of the statute and regulations." The court ruled that the Provider Reimbursement Review Board had jurisdiction to review St. James' self-disallowance because the Board's jurisdiction may be invoked by a provider if the provider is dissatisfied with the amount of total program reimbursement and the amount in controversy exceeds $10,000, regardless of whether the fiscal intermediary was presented with the question of the reimbursement of the telephone costs.

Turning to the merits of St. James' claim for reimbursement of the expenses it incurred in furnishing bedside telephones to Medicare patients, the court noted that the telephones were used by both hospital personnel and patients alike. The district court found persuasive the expert medical testimony and clinical studies supporting the theory that bedside telephones had therapeutic value. While noting that the Secretary has broad discretion in adopting regulations governing payment to Medicare providers, the district court went on to find that the Medicare section disallowing reimbursement for "personal comfort items" was not intended to exclude the payment for patient telephones *per se*. Rather, the court reasoned that it was Congress' intent to exclude such items from coverage if they were required only for the convenience of a patient and had no meaningful relationship to the medical treatment of an illness or an injury or the functioning of a malformed body member. It was the court's decision that a bedside telephone had therapeutic value and was essential to the delivery of health care and therefore the Secretary of Health and Human Services abused his discretion in refusing to reimburse hospitals for the costs incurred in supplying Medicare patients with

bedside telephones. The Secretary has appealed from the decision of the district court.

ISSUES PRESENTED

Issue 1: Is the cost of providing a percentage of free care to indigent persons pursuant to a hospital's obligation under the Hill-Burton Act reimbursable under Medicare as a reasonable cost of providing medical services?

Issue 2: Did the district court err in ruling that patient bedside telephones are not "personal comfort items" within the meaning of the Medicare Act?

1. *Hill-Burton Costs*[7]

Subchapter XVIII of the Social Security Act, entitled Health Insurance for Aged and Disabled, authorizes the payment of "reasonable costs" to qualified hospitals that provide medical services to Medicare beneficiaries and directs and empowers the Secretary of Health and Human Services to draft regulations to define and interpret what constitutes "reasonable costs" within the parameters of the Social Security Act. 42 U.S.C. § 1395x(v). On August 17, 1982, Congress passed section 106 of the Tax Equity & Fiscal Responsibility Act of 1982, and the bill became effective September 3, 1982. Section 106 provides:

> "(a) Section 1861(v)(1) of the Social Security Act [42 U.S.C. § 1395x(v)(1)] is amended by adding at the end the following new subparagraph:
>
> > '(M) Such regualtions shall provide that costs respecting care provided by a provider of services, pursuant to an assurance under Title VI or XVI of the Public Health Service Act that the provider will make available a reasonable volume of services to persons unable to pay therefore, shall not be allowable as reasonable costs.'

[7]For a discussion of the Hill-Burton Act, *see* note 4, *infra*.

(b) The amendment made by subsection (a) shall be effective with respect to any costs incurred under Title XVIII of the Social Security Act, except that it shall not apply to costs which have been allowed prior to the date of the enactment of this Act pursuant to the final court order affirmed by a United States Court of Appeals."

Accompanying this provision the Congress included the following statements of congressional intent:

"House Committee Provision

The House Committee Provision requires the Secretary to provide, by regulation, that the costs incurred by a hospital or skilled nursing facility in complying with its free care obligation under the Hill-Burton Act would not be considered reasonable costs for purposes of Medicare reimbursement. The provision is effective for costs incurred on or after date of enactment.

Conference Agreement

The Conference Agreement includes the House Committee Provision. *The provision is intended to clarify that Hill-Burton free care costs have never been, and are not, allowable for Medicare reimbursement purposes.* The provision, therefore, applies to all such costs that have been, or will be incurred except those recognized by the final judgment of a U. S. Court of Appeals entered into prior to enactment."

H.R. Rep. No. 97-160, 97th Cong., 2d Sess. at 431 (8/17/82) (emphasis supplied).

From the inception of the Medicare Program, the Secretary has adhered to the intent of Congress that Medicare was established exclusively to reimburse hospitals for the reasonable cost of providing medical treatment to those individuals who qualify as Medicare beneficiaries and not to reimburse hospitals for their charity obligations under the Hill-Burton Act. In response to the congressional mandate contained in section 106, the Secretary adopted regulations revising 42 C.F.R. § 405.420(b)(2), (g), "to state explicitly that

uncompensated services furnished in fulfillment of a Hill-Burton free care obligation are considered charity allowances and as such cannot be considered allowable costs in computing Medicare reimbursement for providers." 47 Fed. Reg. No. 191 October 1, 1982 at 43657. In support of his regulation, the Secretary further noted:

> "This rule is consistent with long standing Medicare policy in this area, and, as noted in the preceding section of this preamble, is explicitly required by Sections 1861 (v)(1) of the Act (as amended by Section 106 of Pub. L.97-248). We believe this change will clarify our regulations and prevent further disputes with providers and others on this issue. . . .
>
> Section 106 of Pub.L. 97-248 is effective with respect to all costs incurred under Medicare, both before and after enactment of the amendment, except those specific costs allowed under court order in the *Presbyterian Hospital decision. Consequently, this rule is applicable to all past disputes concerning Medicare disallowances of costs of free care furnished under a Hill-Burton obligation except those cost years specifically litigated in the Presbyterian Hospital* case, as well as future treatment of these costs. Any Hill-Burton costs paid by Medicare under the principal of the *Presbyterian* decision, but not specifically litigated therein, are impacted by this statutory amendment. These cost reports will be reopened and the Hill-Burton free care costs will be disallowed."

Id.

Saint Mary's and St. James' Hospitals challenge the congressional amendment and the subsequent regulations promulgated by the Secretary on the grounds that these governmental actions repudiate the hospitals' vested contractual rights to Medicare reimbursement for Hill-Burton indigent care costs and thus constitute a taking of property without just compensation in violation of the fifth amendment. Moreover, the hospitals assert that all patients should share proportionately in defraying the costs of providing the free care to indigents pursuant to the Hill-Burton Act because all patients benefit

from the hospitals' use of Hill-Burton funds. Since the Secretary requires hospitals to accept Medicare patients if they previously received Hill-Burton funds and now refuses to reimburse those hospitals for the Medicare patients' share of the Hill-Burton charity care costs, the hospitals assert that they are being forced to operate at a loss when treating their Medicare patients. However, our review of the Medicare Act and the Hill-Burton Act reveals that these two Acts as established are two separate and distinct federal programs, each designed to accomplish a distinctly different purpose. The Hill-Burton Act was designed to promote the construction and modernization of hospitals, and as a *quid pro quo* for the recipient of Hill-Burton funds, participating hospitals agreed to provide a percentage of charity care to local indigents. The Medicare Act, on the other hand, was adopted only to provide medical care for the disabled and the aged who qualify as Medicare beneficiaries. It was Congress' intent that these two programs remain separate and apart from each other and that hospitals should not be reimbursed by one program (Medicare) for the care they provide in fulfillment of the other, their Hill-Burton obligations. Thus, it is evident from the legislative history of the two Acts and the Secretary's long standing policy and from the language of the statutes that Congress never intended to allow the Medicare program to reimburse hospitals for a percentage of their annual Hill-Burton free care costs.

To date, two circuit courts of appeals have addressed the application of section 106 of the Tax Equity and Fiscal Responsibility Act of 1982. In *Harper-Grace Hospitals v. Schweiker*, 691 F.2d 808 (6th Cir. 1982), the Sixth Circuit applied section 106 and in doing so affirmed the decision of the district court that the costs of providing free care to indigents pursuant to the hospital's obligation as a recipient of Hill-Burton funds were not reimbursable costs under the Medicare Act. However, the court did not address the issue of the constitutionality of section 106, but rather relied upon the general rule that courts must apply the law that is in effect at the time the court renders its decision. See *Bradley v. Richmond School Board*, 416 U.S. 696, 711, 94 S. Ct. 2006, 2016, 40 L.Ed.2d 476 (1974).

In a recent decision, the Eighth Circuit reversed the finding of the district court and held that the Secretary of the Department of Health and Human Services was correct when he relied on his regulation and denied the hospitals Medicare reimbursement for the costs the hospitals incurred in providing a percentage of free care to local indigents pursuant to the Hill-Burton contractual agreement. *Metropolitan Medical Center v. Harris,* 693 F.2d 775 (8th Cir. 1982). The court declined to rely on the retroactive application of section 106 of the Tax Equity and Fiscal Responsibility Act and instead rested its decision on the fact that the Hill-Burton Act and the Medicare Act embody separate and distinct federal programs and the legislative history of each revealed that Congress never intended to allow the use of Medicare funds to reimburse hospitals for the Medicare percentage of the free care rendered to indigents under the Hill-Burton Act. The court rejected the hospitals' claim that they had a right to Medicare reimbursement for the free care they provide to indigents as recipients of Hill-Burton construction aid because "[t]he text of the Act, its implementing regulations, its legislative history and the case law construing it all [demonstrate] that Medicare reimbursement for free care costs is inconsistent with the Hill-Burton Act." *Metropolitan Medical Center,* 693 F.2d at 782.

In another case, *Arlington Hospital v. Schweiker,* 547 F. Supp. 670 (D. Va. 1982), the district court found section 106 constitutionally sound in the face of an attack based upon an uncompensated "taking" within the meaning of the fifth amendment. The court balanced the nature and the strength of the public interest served by section 106 against the nature of the hospital's asserted right to reimbursement and found that the "strength of the public interest involved, and the relative insubstantiality of the plaintiff's interest" required the court to uphold the constitutionality of section 106. *Id.* at 675. We agree with the overall reasoning of the Sixth and Eighth Circuit Courts and the specific reasoning in the *Arlington Hospital* case dealing with section 106, and in so ruling we hold that strong public policy outweighs the hospitals' insubstantial interest, and section 106 is clear in that it is nothing more than the reaffirmation of the longstanding policy that it was never

the intent of Congress to allow Medicare payments to be used to reimburse hospitals for the percentage of free care they provide indigents in repayment of their obligations under the Hill-Burton Act.

To reach any other conclusion would put the government in the anomalous position of acting as a permanent life support system for health care facilities who provide services for the indigent without requiring that the hospitals fulfill the contractual obligations they incurred when accepting Hill-Burton funds. This type of financial reimbursement advocated by the hospitals is totally inconsistent with the principles of the Hill-Burton Act. We believe it is incumbent upon hospital executives to administer their respective hospitals in a fiscally responsible manner, contingent upon the reasonable cost of the services they provide within the limits of the Medicare guidelines. We refuse to permit hospitals to subvert federal aid programs through the use of other federal funds to subsidize the financial dilemma they themselves created.

It is well settled "that legislative acts adjusting the burdens and benefits of economic life come to the Court with a presumption of constitutionality and that the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 15, 96 S. Ct. 2882, 2892, 49 L.Ed.2d 752 (1976). In analyzing the constitutionality of retroactive legislation, case law suggests that courts undertake a balancing of three factors: (1) the nature of the asserted right that is altered by the legislation; (2) the nature and strength of the public interest served by the legislation; and (3) the extent to which the legislation impairs the asserted interest. *See Nachman Corp. v. Pension Benefit Guaranty Corp.*, 592 F.2d 947, 959-60 (7th Cir. 1979).

As to the first element, the hospitals' purported right to Medicare reimbursement for Hill-Burton uncompensated care costs was never expressly granted by either statute or regulation. Rather, this alleged right simply arises out of the hospitals' reading of the Medicare Act through rose colored glasses, a

reading which is to the hospitals' pecuniary advantage, and the Fifth Circuit's interpretation of the Medicare Act and the Hill-Burton Act. *See Presbyterian Hospital of Dallas v. Harris*, 638 F.2d 1381, 1382 (5th Cir. 1981). However, neither the *Harris* decision nor the hospitals' reading of the Medicare Act rise to the level of establishing a "vested right" in hospitals to receive Medicare reimbursement for Hill-Burton uncompensated care costs, but merely represents a "hospital administrator's dream" and the wild expectation that hospitals should now receive even more government money for the services they have previously contractually agreed to provide to indigents in repayment of their Hill-Burton grants. There is not a scintilla of proof in this record that Congress ever intended the Medicare program to reimburse hospitals for the Medicare percentage of the cost of providing medical care pursuant to their Hill-Burton obligations.

The public interest to be served by section 106 is evident from our review of the legislative history of that section. Congress was acting to remedy what it perceived as a misinterpretation of the Medicare Act in recent litigation. There is clearly a strong public interest in the proper interpretation of congressional acts, and the adoption of section 106 by Congress was merely to clarify an already accepted fact that Medicare was never intended to provide hospitals with a second cash payment for the care they provide local indigents and is necessary to eliminate "windfalls from an unexpected judicial decision." C. Hochman, *The Supreme Court and Constitutionality of Retroactive legislation*, 79 Harv. L. Rev. 692, 705 (1960). Furthermore, public policy supports the application of section 106 because to allow hospitals to use one federal program to fund their obligations under another in an attempt to "charge back" their excess costs to the government runs contrary to a reasonable reading of the two Acts. Therefore, we hold that section 106 is constitutional.

2. *Bedside Telephone*

Before reaching the merits of the district court's decision that patient bedside telephones are not "personal comfort items" within the meaning of the Medicare Act, we must

first determine whether the district court had jurisdiction to decide the question. 42 U.S.C. § 1395oo(g) states:

> "[t]he finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because such items or services are listed in section 1395y of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section."

The Secretary contends that the courts do not have jurisdiction over the telephone cost reimbursement issue because the fiscal intermediary disallowed the cost of patient bedside telephones on the grounds they are "personal comfort items." Because the term "personal comfort item" is "listed in section 1395y," the Secretary asserts that section 1395oo(g) restricts the jurisdiction of the courts in the following language: "The finding of the fiscal intermediary . . . shall not be reviewed by the Board, or any any court. . . ." However, we do not agree with the Secretary's position that the telephone reimbursement cost issue cannot be reviewed by the courts. There is no definition or description of the term "personal comfort item" in the statute, and therefore, pursuant to his statutory duty and authority, the Secretary adopted regulations and interpreted the term "personal comfort item" to include personal telephones. Thus, we are faced only with a challenge to the Secretary's interpretation contained in his regulations of the term "personal comfort item." Contrary to the Secretary's position, section 1395oo(g) does not restrict this court's jurisdiction to review the Secretary's interpretation of what a personal comfort item consists of.

In a second challenge, the Secretary also contends that the Provider Reimbursement Review Board was without jurisdiction to act upon St. James Hosptial's claim for reimbursement of the cost of bedside telephones because the hospital itself had "self-disallowed" the costs when they filed worksheet A-8 of the Medicare Costs Reports. The Secretary takes the position that the relevant statutes require an initial presentation of the question of the reimbursement of telephone costs to the fiscal intermediary before the hospital is entitled to a

hearing by the Provider Reimbursement Reivew Board. 42 U.S.C. § 1395oo(d) provides that:

> "The Board shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report *and to make any other revisions on matters covered by such cost report* (including revisions adverse to the provider of services) *even though such matters were not considered by the intermediary in making such final determination.*" (Emphasis supplied).

This section vests broad authority in the Provider Reimbursement Review Board to review the finding of the fiscal intermediary and make any adjustment to the cost reports the Board deems necessary. As the statute itself expressly states, the Board may consider any matter "even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. § 1395oo(d). Therefore, since the statute allows the Board to consider matters outside of the cost reports, we hold the Provider Reimbursement Review Board had the authority to consider whether the costs of providing Medicare patients with bedside telephones are reimbursable expenses under the Medicare Act.

Reaching the merits of the court's decision to overrule the Secretary and order reimbursement under the Medicare Act of the cost of providing Medicare patients with bedside telephones, we initially note that 42 U.S.C. § 1395hh grants the Secretary the broad discretionary power to "prescribe such regulations as may be necessary to carry out the administration of the insurance programs under this subchapter." While Congress has mandated that no payment may be made for items "which constitute personal comfort items," 42 U.S.C. § 1395y(a)(6), Congress did not define the term "personal comfort item." Therefore, the Secretary of the Department of Health and Human Services, as the Administrator of the Medicare Program had the duty to draft and implement the following regulation defining the term "personal comfort item:"

> "no payment may be made for any expenses incurred for the following items or services:

(j) Personal Comfort Items and Services (for example a television set, or telephone service, etc);"

42 C.F.R. § 405.310.

It is the duty of the courts to interpret congressional acts, and though courts are not bound by interpretative regulations such as section 405.310, *Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S. Ct. 161, 164, 89 L.Ed. 124 (1944), courts will defer to the agency's judgment unless it can be shown that the agency's determination was arbitrary and capricious or constituted an abuse of discretion. 5 U.S.C. § 706(2)(A). *See also Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416, 91 S. Ct. 814, 823, 28 L.Ed.2d 136 (1971). As recently stated by the Supreme Court, "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making such decisions. *See Parham v. J.R.*, 442 U.S. 584, 607, 99 S. Ct. 2493, 2506-2507, 61 L.Ed.2d 101 (1979); *Bell v. Wolfish, supra*, 441 U.S. at 544, 99 S. Ct. [1861] at 1877 [60 L.Ed.2d 447] (Courts should not 'second-guess the expert Administrator on matters on which they are better informed.')." *Youngberg v. Romeo*, ___ U.S. ___, ___, 102 S. Ct. 2452, 2462, 73 L.Ed.2d 28 (1982). The Secretary's regulation banning the reimbursement of the cost of a telephone used for a Medicare patient's personal comfort is clearly authorized by 42 U.S.C. § 1395y(a)(6). Since the Secretary has the broad authority to adopt regulations within the confines of the stated congressional intent, and because St. James has failed to show that the Secretary abused his discretion in determining that bedside telephones are personal comfort items, we hold that the cost of providing a Medicare patient with a bedside telephone is not a reimbursable cost under the Medicare program.

In sum, we defer to the professional expertise of the Secretary of the Department of Health and Human Services, and in doing so we uphold the Secretary's determination to exclude from Medicare reimbursement the "average cost" of each telephone supplied to a Medicare beneficiary and we further hold that the Secretary's regulation which prohibits the reimbursement of hospitals for bedside telephones provided

as personal comfort items to Medicare patients is valid and enforceable.

As pointed out earlier, we hold that section 106 of the Tax Equity and Fiscal Responsibility Act of 1982 which prohibits the reimbursement by Medicare of costs incurred by the provider hospitals in fulfillment of their obligation to provide a percentage of free care to indigents under the Hill-Burton Act is constitutional and thus, we affirm the decision of *Saint Mary of Nazareth Hospital v. Department of Health and Human Services,* and reverse *St. James Hospital v. Schweiker.*

IN THE

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ST. JAMES HOSPITAL,
Plaintiff,

v.

PATRICIA ROBERTS HARRIS, SECRETARY
DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendant.

Civil No. 80 C 735

Filed: December 4, 1981

LEIGHTON, District Judge

This civil action arises from a dispute between a hospital and the Secretary of Health and Human Services concerning reimbursement under the Medicare Act of two classes of costs: (1) those the hospital incurred in providing medical care to indigent patients, a requirement imposed by statute and rules on hospitals which have received Hill-Burton construction grants; and (2) those incurred by the hospital in providing bedside telephones to Medicare beneficiaries. The hospital, proceeding under regulations adopted by the Secretary, made a self-disallowance as to the telephone costs and submitted a

report for reimbursement of the costs incurred in furnishing medical care to indigent patients; they were denied. It appealed to the Provider Reimbursement Review Board in accordance with 42 U.S.C. § 1395oo; the Intermediary's decision was upheld. The Secretary's responsible subordinate, the Administrator of the Health Care Financing Administration, declined to affirm, reverse, or modify the Board's decisions, thereby allowing them to stand.

This suit, invoking jurisdiction pursuant to 42 U.S.C. § 1395oo(d) and procedurally governed by 5 U.S.C. §§701 *et seq.*, requires review of the Secretary's decisions which may be overturned only if they were arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law, or unsupported by substantial evidence. The clause is before the court on cross-motions for summary judgement. There are no material issues of fact to be resolved. This being so, and from applicable law, the court concludes that on the issue whether, for the year in question, Medicare should reimburse the hospital a percentage of the costs it incurred in connection with its obligations under the Hill-Burton Act to provide free medical care to indigents; and on the issue whether for the same year the hospital should be reimbursed the costs it incurred in furnishing Medicare patients with bedside telephones, St. James is entitled to judgment as a matter of law. Therefore, its motion for summary judgment is granted; the Secretary's is denied.

I

St. James Hospital is a short-term, acute care general hospital located in Chicago Heights, Illinois. It is a qualified provider of medical services under Part A of the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395c *et seq.*, which Congress enacted in 1965. These provisions of the Act furnish federal funding of medical care for the aged and disabled. Under these provisions, participating providers of health services like St. James Hospital, are reimbursed from trust funds for the "reasonable cost" of covered services. As defined in 42 U.S.C. § 1395x(v)(1)(A) "reasonable cost" means the actual cost of providing in-patient hospital

care; it is an all-inclusive term, unless specifically identified and excluded by 42 U.S.C. § 1395y. Therefore, the Medicare program reimburses hospitals providing services to Medicare beneficiaries the lesser of their charges or the reasonable cost of furnishing such services.

The Secretary of Health and Human Services administers the program through fiscal intermediaries who review cost reports submitted by providers, and who determine the amount of costs that will be reimbursed. Fiscal intermediaries and other agents of the Secretary are guided by rules and regulations which must be consistent with the statute and necessary to the efficient discharge of the statutory functions. 42 C.F.R. § 405.420(g) is the regulation controlling the Hill-Burton issue, reimbursement of the claimed percentage of uncompensated care costs. It provides, in relevant part, that "[c]harity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs." The statutory provision authorizing publication of this regulation is 42 U.S.C. § 1395x(v)(1)(A) which states that "[t]he reasonable costs of any services shall be the cost actually incurred, . . . and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included . . . ."

Between the years 1959 and 1967, St. James, as part of construction financing transactions, received Hill-Burton grants totaling $1,593,000. A condition of these grants, as provided in 42 U.S.C. § 291e(e)(2), was the obligation of the hospital to furnish indigents access to a reasonable volume of free or reduced-cost medical care. Accordingly, St. James provided free or reduced-cost care to those unable to pay, persons who were emergency cases or were in urgent need of hospital services. However, in 1972, as a result of litigation concerning obligations of Hill-Burton grantees, the Secretary promulgated 42 C.F.R. § 53.111 which, in Subparagraph (d), established a presumptive compliance guideline and furnished three methods of proving that a hospital has complied with the terms of a grant. St. James chose one of these and proceeded to budget for and pay the cost of uncompensated care for those unable to pay. In 1977, the year at issue in this case, and

based on the adopted formula, the hospital provided such care in the amount of $159,300. This was a substantial monetary increase over the value of uncompensated care which St. James had provided prior to promulgation of the regulation. Then, spreading the total cost of uncompensated medical care for 1977 throughout its hospital operations, St. James calculated the percentage of its hospital services represented by Medicare patients and concluded that the same percentage of uncompensated care costs was a "reasonable cost" it had incurred in furnishing medical care to Medicare beneficiaries. It treated this amount as a cost arising out of a financial transaction; that is, the Hill-Burton construction grants. St. James included this sum in its 1977 cost report and asked for reimbursement of this amount. The Intermediary disallowed reimbursement on the ground that uncompensated care represented charity within the meaning of the Secretary's regulations, 42 C.F.R. § 405.420. With one of its three members dissenting, the Provider Reimbursement Review Board upheld the Intermediary; the disallowance ultimately became the Secretary's decision.

In the same cost year, St. James furnished bedside telephones used by staff and physician personnel for hospital purposes and by patients for personal use. Use of the telephones by hospital personnel included alerting the cardiac resuscitation team, calling for inhalation therapy, physical therapy, patient transport, and administrative personnel in the normal course of the duties. Patient usage of the telephones included not only communication with friends and family members, but also contacts with hospital staff persons such as the ombudsman, admitting and discharging personnel and social workers. In completing the cost report, St. James followed Section 2601.1 of the Provider Reimbursement Manual, but particularly, the Secretary's regulation published in 42 C.F.R. § 405.310(j) and providing that

> Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services:
>
> * * * * *
>
> (j) Personal confort items and services (for example a television set, or telephone service, etc.).

A provision of the Medicare Act, 42 U.S.C. § 1395y(a)(6) excludes certain costs from coverage by stating that

> Notwithstanding any other provision of this subchapter, no payment may be made under part A or part B of this subchapter for any expenses incurred for items or services–
>
> * * * * *
>
> (6) which constitute personal comfort items;

Prompted by what these sources instructed, all of them emanating from either the Secretary or her subordinates, the hospital made cost entries on Worksheet A-8 of its 1977 cost report. This operated to effect a self-disallowance of the patient telephone costs and thus obviated any need for an adjustment by the Intermediary.

The Intermediary denied all the reimbursements claimed in the cost report, and thereafter, St. James joined a number of Florida hospitals in a group appeal challenging refusal of the Medicare program to reimburse the costs of patient bedside telephones and, in the alternative, Medicare's requirement that average costing be used to determine the amount of nonallowable patient telephone costs rather than incremental or direct costing. The hospitals supported their claim for reimbursement of bedside telephone costs with clinical studies and expert medical testimony which they claimed demonstrated that for a hospital patient a bedside telephone was a part of therapy rather than a item of personal comfort. The Intermediary countered this evidence with the testimony of a college professor whose opinion was that the studies conducted by the hospitals were not statistically valid; he expressed the objection that they had been conducted by using an opportunity sample in which all consenting patients over the age of 18 were tested, rather than a sample that not only chose randomly among a hospital's patients, but included nonhospitalized members of the community.

After hearing the case, the Board found "[t]hat the Providers involved it this appeal [St. James and the Florida hospitals], have conducted in-depth studies and offered expert testimony which demonstrated that patient telephones have therapeutic value. The Board is very impressed with the Providers'

arguments and, in fact, agrees that the patient telephone should be a covered service. However, this Board does not have the authority to rule on coverage issues and is locked into the Regulation that states that the patient telephone is a luxury item. The Board finds that the controlling Regulations and Program Policy require the exclusion from allowable costs of all costs associated with telephone services and other personal comfort items which are used for the convenience of patients." On these findings, the Board decided "[t]hat the Intermediary's adjustment to disallow patient telephone cost is affirmed." This decision, as in the Hill-Burton issue, also became that of the Secretary.

II

A

In support of the contention that it is entitled to judgment as a matter of law on the free medical care issue, St. James Hospital argues that the Provider Reimbursement Review Board erred in finding the Intermediary presented substantial evidence which showed that the Hill-Burton uncompensated care costs constituted charity care. As a matter of fact, argues the hospital, the record before the Board, and thus the one before the Secretary, showed that the Intermediary did not present any evidence. According to the hospital, its evidence established, without contradiction, that the free care it gave to indigents during the cost year involved was rendered by it pursuant to legal compulsion under Hill-Burton regulations, 42 C.F.R. §§ 53.111, 124.06 and 124.607(b), all of them directions issued to hospitals like St. James by the Secretary. Noncompliance with the Secretary's regulations meant possible loss of licensure, and enforcement against it of contractual obligations it assumed under the grant agreements to provide such services. The hospital argues that the uncompensated care it furnished (1) was not rendered voluntarily, (2) would not have been furnished but for the legal compulsion enforced by the Secretary, (3) constituted a cost of providing care through the Hill-Burton financed facility just as interest and other financing costs are costs of providing care, and (4)

generated costs which would be shifted to and paid by non-Medicare patients if Medicare does not bear its share of such financing obligations. As against all of its evidence, according to St. James, the Intermediary supported disallowance with only a series of documents consisting mostly of excerpts from the legislative history of the Medicare Act.

The Secretary counters with the argument that in the light of unequivocal statutory language in both the Medicare and Hill-Burton statutes, she had determined, and her subordinates had properly decided, that the costs of providing uncompensated care to non-Medicare beneficiaries should not be borne by the Medicare program. She insists that St. James is seeking reimbursement from Medicare trust funds for costs it was required to incur in complying with assurances it had given in return for Hill-Burton grant aids. The Secretary argues that hospitals, like St. James, which have received Hill-Burton assistance, are obligated by law, and by the terms of their grants, to provide a reasonable level of uncompensated care to indigent persons; and that St. James' position in this case concerning reimbursement of free care costs is contrary to the unequivocal language of the Medicare Act which precludes reimbursement by the program for services rendered to persons not covered by its provisions. Congress, the Secretary insists, has given her wide latitude in determining what constitutes reasonable costs. In exercising this congressional authority, she has determined that reasonable costs do not include charity allowances which she defines as reductions in revenue by the provider of services because of the indigence of the patient. Charity allowances, argues the Secretary, bear no relationship to beneficiaries of the Medicare program; and she points to what she interprets as the controlling regulations, 42 C.F.R. § 405.420 Subparagraphs (b)(2) and (g) defining "charity allowances", and where she has stated that "[c]harity allowances have no relationship to beneficiaries of health insurance program and are not allowable costs."

B

Concerning its claim that Medicare should reimburse a provider the costs it incurred in furnishing Medicare patients with bedside telephones, St. James argues it was error for the Board

to determine that 42 C.F.R. § 405.310(j) requires disallowance of such costs despite the Board's recognition that there was evidence which showed telephones so used had therapeutic value; and despite the Board's conclusion that such costs should be reimbursable under the Medicare program. St. James argues that given the evidence introduced by the hospitals at the joint hearing, evidence which showed that patient bedside telephones had therapeutic value, the Secretary's regulation should not be read to preclude reimbursement of such costs because 42 U.S.C. § 1395y(a)(6), the statute which the regulatory provision seeks to interpret, only proscribes reimbursement of expenses "which constitute personal comfort items. . . ." The legislative history of this statute, the hospital insists, does not preclude reimbursement to a provider of costs for bedside telephones furnished patients unless it can be established that the telephones were not furnished by the hospital as part of therapy, but requested by a patient for his or her personal comfort. And, insists the hospital, if the Secretary's regulation, 42 C.F.R. § 405.310(j), does require disallowance of patient bedside telephone costs, it contravenes the underlying purposes of the Medicare Act, and constitutes action by the Secretary that would violate protected constitutional rights of a provider like St. James.

The Secretary responds with an argument that first raises a question of procedure. She argues that this Court lacks subject matter jurisdiction over the claim because the Board refused to rule on St. James' self-adjusting disallowance for the patient bedside telephone costs. Only the Intermediary, which did not act, says the Secretary, could have reopened St. James' 1977 cost report; and no such action was taken; therefore, there is nothing, as to the telephone cost claim, for this court to review.

St. James, however, argues that the Board erred procedurally in refusing to assert jurisdiction over the claim concerning the bedside telephones, one concerning which, admittedly, the Intermediary made no adjustment. It contends that the procedure followed was one directed by the Secretary in her instructions not only in regulations but in the provisions of

Chapter 21 of the Provider Reimbursement Manual (Section 2106.01). The hospital insists that denial to it of a hearing on this claim by the Board's refusal to entertain jurisdiction, and the Secretary's argument attacking this court's power to review, will close access to judicial review of an arbitrary and capricious decision.

In addition, the Secretary questions this court's subject matter jurisdiction to review the Intermediary's determination in the Florida appeal that costs incurred in furnishing patients beside telephones are not reimbursable on the ground that 42 U.S.C. § 1395oo(g) limits the Board's review. That statute provides:

> The finding of a fiscal intermediary that no payment may be made under this subchapter for any expenses incurred for items or services furnished to an individual because of this title shall not be reviewed by the Board, or by any court pursuant to an action brought under subsection (f) of this section.

As to the merits of the issue, the Secretary argues that 42 C.F.R. § 405.310(j), her regulation excluding coverage of private patient telephones as personal comfort items, is valid because it is reasonably related to the purposes of the Medicare Act. She argues that applicable statutory provisions support her decision to exclude patient bedside telephones from Medicare reimbursement because they are personal comfort items; and in any event, evidence presented to the Board in the joint appeal did not establish the therapeutic value of private, in-room patient telephones. Thus, it can be seen that resolution of the issues presented requires this court to determine whether the Secretary has correctly construed the applicable provisions of the Medicare Act, and has reasonably applied the regulations on which she relies for disallowance of the costs reimbursements in this care.

III

Generally, when the meaning of a regulation is within the expertise of an agency, courts will defer to that agency's construction. This is so because the agency's expertise makes it

particularly suited to interpret the language of its regulations; and ordinarily its construction will be affirmed if it is not clearly erroneous or inconsistent with other regulations. *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123, 131 (9th Cir. 1980); *see Udall v. Tallman*, 380 U.S. 1, 16-17, 85 S. Ct. 792, 801, 13 L.Ed.2d 616 (1965). Particularly is this true where the agency expertise is in a substantive area, and where the regulations were promulgated pursuant to congressional authorization. *White Memorial Medical Center v. Schweiker*, 640 F.2d 1126, 1129 (9th Cir. 1981); *Mercy Hospital and Medical Center, San Diego v. Harris*, 625 F.2d 905, 907 (9th Cir. 1980). However, the deference which a court will afford an agency's interpretation of its regulations is not total, *Pacific Coast Medical Enterprises v. Harris, supra*; the degree of such deference varies with circumstances. *St. John's Hickey Memorial Hospital v. Califano*, 599 F.2d 803, 812 (7th Cir. 1979).

As to another aspect, the scope of this court's review of the final decisions of the Secretary is determined by the provisions of Section 701 *et seq.* of Title 5, U.S.C., pursuant to Section 1878(f) of the Social Security Act, 42 U.S.C. § 1395oo(f). *Pacific Coast Medical Enterprises v. Califano*, 440 F.Supp. 296, 303 (C.D.Cal. 1977). Thus guided, this court must determine whether the decisions under review were based on a consideration of the relevant factors, or whether there has been a clear error of judgment. "Although this inquiry into the facts is to be searching and careful, the ultimate standard of review is a narrow one. The court is not empowered to substitute its judgment for that of the agency." *Bowman Transportation, Inc. v. Arkansas-Best Freight System, Inc.*, 419 U.S. 281, 285, 95 S. Ct. 438, 441, 42 L.Ed.2d 447 (1974), quoting *Citizens to Preserve Overton Park v. Volpe*, 401 U.S. 402, 416 91 S. Ct. 814, 823, 28 L.Ed.2d 136 (1971).

In this case, the record before the Secretary contained uncontradicted evidence that in 1977, the cost year at issue, St. James Hospital was obliged by law to budget for and pay the costs of uncompensated care furnished those unable to pay. This obligation was imposed by the Hill-Burton Act, 42 U.S.C. § 291 *et seq.*, the statute under which St. James, during the period 1959 and 1967, received grants totaling $1,593,000 as part of construction financing transactions.

The terms of 42 C.F.R. § 53.111 by which the Secretary enforces this obligation are mandatory. Subparagraph (d) of the regulation required a Hill-Burton grantee hospital like St. James to show compliance by either budgeting for the support of or making available on request, uncompensated services at a level not less than the lesser of 3% of operating costs, 10% of the Hill-Burton grants received, or adoption of a policy that did not exclude any person from admission on the ground that such person is unable to pay for needed services.

St. James chose the second of the three methods of compliance. In the community served, it treated both Medicare and non-Medicare patients. It incurred and incurs reasonable and necessary costs in providing medical care to its general patient population. One of these costs is the maintenace of the facilities it constructed, financed by the grants received under the Hill-Burton Act. In the year 1977, the year at issue, St. James treated the uncompensated care it furnished those unable to pay as a cost incurred in furnishing hospital services. Before the Intermediary, and in its appeal to the Provider Reimbursement Review Board, St. James produced evidence showing it had determined the percentage its Medicare patients represented to its general patient population; and utilizing that formula, calculated that Medicare's portion of the $159,300 uncompensated care for 1977 was $42,000.

It was this amount for which St. James sought reimbursement in its cost report from the Medicare program. The Intermediary disallowed this reimbursement request on the ground that the sums paid by St. James to furnish uncompensated care to those unable to pay represented charity within the meaning of 42 C.F.R. § 405.420(c). The Intermediary did not introduce evidence; it relied entirely on excerpts from provisions of the Medicare Act and on 42 C.F.R. § 405.420(c). This regulation attempts to deal with normal accounting treatment of factors which affect costs, and provides that "[b]ad debts, charity and courtesy allowances represent reductions in revenue." Subparagraph (g) thereof categorically states that "[c]harity allowances have no relationship to beneficiaries of the health insurance program and are not allowable costs."

It is worth noting that this regulation does not define charity to include costs which a provider incurs in rendering uncompensated care to indigents, and thus not an allowable reimbursement. In those portions of its provisions that deal with the concept of charity, the regulation merely states a conclusion which every provider knows: free medical service to an indigent patient reduces revenue. Indeed, the regulation does not define the work "charity" as it is used by the Secretary.

It has been said that " '[c]harity' is a matter of description rather than of precise definition, and each case involving determination of that which is charitable must be decided on its own particular facts or circumstances." *Topeka Presbyterian Manor, Inc. v. Board of County Commissioners of Shawnee County,* 195 Kan. 90, 402 P.2d 802, 806 (1965); overruled on other grounds, *Lutheran Home, Inc. v. Board of County Commissioners,* 211 Kan. 270, 505 P.2d 1118 (1973). Mr. Binney, in his famous and widely quoted argument in the Girard will case, defined charity as "[w]hatever is given for the love of God or the love of your neighbor, in the catholic and universal sense, given from these motives and to these ends, free from the stain or taint of every consideration that is personal, private, or selfish." *Vidal v. Girard's Executors,* 2 How. 128, 11 L.Ed. 205 (1844); *see Ould v. Washington Hospital,* 95 U.S. 303, 311, 24 L.Ed 450 (1877). A characteristic of charity is that it is boundless. Paul, when he wrote to the Corinthians, told them that "Charity never ends. . . ." 1 Cor. 13:8 (King James). "Charity", the Court of Appeals for the Third Circuit has had occasion to say, "means such unselfish things as are wont to be done by those who are animated by the virtue of love." *Bok v. McCaughn,* 42 F.2d 616, 619 (3d. Cir. 1930).

Without appearing to be unkind, this court will not hesitate to say that when, during the year 1977, St. James furnished uncompensated care to medical indigents, it was not animated by the virtue of love; its motives were not free of personal, private, or selfish interests; the fact it limited the amount of uncompensated care it would render to 10% of its Hill-Burton grants shows it largesse was not boundless. Therefore, the Secretary's characterization of St. James' 1977 un-

compensated care costs as charity, when it was not, was arbitrary, erroneous, and irrational. *See Pacific Coast Medical Enterprises v. Harris,* 633 F.2d 123, 136 (9th Cir. 1980). These costs were incurred by St. James in the administration of its entire hospital facilities, administration that benefitted Medicare beneficiaries and those outside the program. They were no different than costs which the hospital could have been required to pay as interest on the grants it received under the Hill-Burton Act. Therefore, the Secretary's refusal to set aside disallowance of the uncompensated medical care costs incurred by St. James was an abuse of discretion and not in accordance with law. Her decision cannot stand. *Rapides General Hospital v. Matthews,* 435 F. Supp. 384 (W.D.La. 1977), *vacated and remanded on other grounds,* No. 77-3125 (5th Cir., October 23, 1978) (unpublished order); *Presbyterian Hospital of Dallas v. Harris,* 638 F.2d 1381 (5th Cir. 1981); *cf. St. Johns Hickey Memorial Hospital v. Califano,* 599 F.2d 803 (7th Cir. 1979).

B

The record also disclosed that in the same cost year St. James Hospital furnished Medicare beneficiaries bedside telephones and followed regulations and instructions in completing its cost report; it made entries with respect to the patient telephone costs which effected a self-disallowance. This use of the Secretary's regulation and instructions obviated the need for the Intermediary to disallow the costs which St. James wanted reimbursed; it accomplished what would have been the result had application for reimbursement been made to the Intermediary. The Board ruled, and the Secretary now insists, that because St. James followed regulations and effected a self-disallowance, it has no right to judicial review of the decision that disallowed reimbursement of costs incurred in furnishing Medicare patients with bedside telephones.

This, in the court's judgment, is a hypertechnical construction of the statute and regulations; it conflicts with recent lower decisions where jurisdiction was exercised over portions of costs for which reimbursement was claimed, costs reports having been reopened for some reimbursement claims other than

those appealed by the provider. 42 U.S.C. § 1395oo(a) entitles a Medicare provider with a hearing before the Board with respect to Medicare reimbursements if the provider "is dissatisfied with a final determination of the . . . fiscal intermediary. . . ." The statute does not make an adjustment by the Intermediary a requirement for jurisdiction of the Board. What is required is dissatisfaction by the provider with the "amount of total program reimbursement."

In addition, the statutory language of 42 U.S.C. § 1395oo(d) provides the Board with power to make revisions on matters covered in a cost report being appealed "even though such matters were not considered by the intermediary in making such final determination." The purpose of 42 U.S.C. § 1395oo(d) is to give providers a forum for administrative and judical relief with respect to claims of underpayment by the Medicare program. This special provision is not surprising in light of the statutory scheme. In the case before the court, a provider like St. James is not the beneficiary of the government programs, but a necessary participant in carrying them out. The Secretary has succeeded in establishing that 42 U.S.C. § 1395oo is the only avenue of relief available to a Medicare provider whether in a challenge to an Intermediary determination or in a direct attack on one of the Secretary's regulations. *See, e.g., Dr. John T. MacDonald Foundation v. Califano,* 571 F.2d 328 (5th Cir.) *cert. denied,* 439 U.S. 893, 99 S. Ct. 250, 58 L.Ed.2d 238 (1978); *Appalachian Regional Hospitals, Inc. v. United States,* 576 F.2d 858, 862 (Ct. Cl. 1978); *Association of American Medical Colleges v. Califano,* 569 F.2d 101, 108-110 (D.C. Cir. 1977). Therefore, the Board had jurisdiction over the disallowance; and this court has jurisdiction of the case. *Cleveland Memorial Hospital, Inc. v. Califano,* 444 F. Supp. 125 (E.D.N.C. 1978), 594 F.2d 993 (4th. Cir. 1979). No useful purpose will be served in remanding it either to the Secretary or to the Board; to hold otherwise would subvert the statutory purpose of 42 U.S.C. § 1395oo.

Turning to the merits, the evidence shows without contradiction that the hospital furnished bedside telephones to Medicare patients for use by hospital personnel and physicians in con-

nection with hospitalization and therapy. The telephones were used to alert cardiac resuscitation teams in the event of a cardiac arrest or other cardio-pulmonary emergency, to call hospital personnel who did inhalation and physical therapy, and summon those who transported patients and served them administratively in the discharge of their duties. Patient usage of the bedside telephones included communication with friends, family, and loved ones outside the hospital, but also included communication with hospital personnel such as the ombudsman, social workers, and those who admitted and discharged patients.

The hospitals supported their showing that bedside telephones had therapeutic value with clinical studies and expert medical testimony. Three were studies of patients with and without bedside telephones, and patients vho were without bedside telephones when first tested but who were given telephones and later retested. The studies were (1) an attitudinal or feelings survey prepared and administered by Westinghouse Health Systems, (2) psychiatric anxiety and depress self-rating studies prepared by Dr. William Zung and administered by Westinghouse, and (3) psycholinguistic semantic differential studies prepared by Dr. Charles Osgood and administered by Westinghouse. In addition, clinical studies were prepared and administered by William Convey who monitored and measured the cardio-vascular responses of hospital in-patients to telephone conversations.

The clinicians described their work and gave expert testimony, including demonstrations that touched on levels of anxiety in the morbidity range, such as that shown to exist in a large percentage of patients without bedside telephones. Some gave the opinion that absence of a telephone causes adverse effects on a patient's cardiovascular, gastro-intestinal, genital-urinary, skin and the central nervous system. Doctors Zung and Convey testified that emotional or psychological stress has an effect on the heart rate, blood pressure, endocrine system, pituitary glands, and the adrenalin level of individuals. In addition, Dr. James Lynch and Dr. Sue Ann Thomas of the University of Maryland Psychophysiological Laboratories and Clinics testified as experts, they gave the opinion that patient bedside telephones had a definite therapeutic value.

The Intermediary did not rebut any of this evidence. It called one witness, a college professor whose testimony was an evaluative criticism of the case that had been made by the hospitals. His primary objection to the clinical studies was that they had been conducted by using an opportunity sample that involved patients in a hospital older than 18 years, and who consented to the testing. His view was that the test should have been a random sample that not only chose randomly among hospital patients, but also included nonhospitalized members of the community. He acknowledged, however, that most medical research was proceeded by opportunity samples, and thus was statistically invalid.

The Board, after hearing the evidence, three members participating, one dissenting found that

> The Intermediary has presented evidence to demonstrate that its adjustment to disallow patient telephone costs is proper. In prior decisions this Board has ruled against Providers regarding the patient telephone issue and the Board has stated that, although Providers have argued that the telephone has therapeutic value, none of the Providers had conducted an indepth study to determine same. The Board notes that the Providers involved in this appeal have conducted indepth studies and offered expert testimony which demonstrated that patient telephones have therapeutic value. The Board is very impressed with the Providers' arguments and, in fact, agrees that the patient telephone should be a covered service. However, this Board does not have the authority to rule on coverage issues and is locked into the Regulation that states that the patient telephone is a luxury item.
>
> The Board finds that the controlling Regulations and Program Policy require the exclusion from allowable costs of all costs associated with telephone services and other personal comfort items which are used for the convenience of patients.

It decided, over the objection of the dissenting member, that "the intermediary's adjustment to disallow patient telephone costs is affirmed." Thus, despite recognizing the showing that patient bedside telephones had therapeutic value, and agreeing with the hospitals that such telephones should be a covered service, the Board ruled that it was bound, "locked into the regulation", 42 C.F.R. § 405.310(j) and so had to affirm the Intermediary's disallowance of the patient bedside telephone costs. Therefore, the issue to be resolved is whether the Secretary's action that allowed the Board's decision to stand is supported by substantial evidence when the record is viewed as a whole, 42 U.S.C. § 1395oo(d); 5 U.S.C. § 706(2)(A). In addition, this court must determine, since a challenge is made to the validity of a regulation promulgated by the Secretary, whether she exercised discretion through a reasoned consideration of the relevant factors and did not commit a clear error of judgment. *The Diplomat Lakewood, Inc. v. Harris*, 613 F.2d 1009, 1018-19 (D.C. Cir. 1979).

"Substantial evidence" is not simply some evidence, or even a great deal; "[r]ather, the 'substantiality of evidence must take into account whatever in the record fairly detracts from its weight.' " *Beavers v. Secretary of Health, Ed. & Welfare*, 577 F.2d 383, 387 (6th Cir. 1978). The term means more than a scintilla, and is such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. *Beasley v. Califano*, 608 F.2d 1162, 1166 (8th Cir. 1979). It is a term of art that describes the framework within which a reviewing court judges an administrative record. *OKC Corporation v. Oskey Gasoline and Oil Company*, 381 F. Supp. 865, 868 (N.D. Tex. 1974).

It is true that opinions of competent persons may constitute "substantial evidence" to sustain an administrative determination. *Richardson v. Perales*, 402 U.S. 389, 402, 91 S. Ct. 1420, 1427, 28 L.Ed.2d 842 (1971); *Turnbull, Inc. v. United States*, 389 F.2d 1007, 1014 (Ct.Cl. 1967). However, an administrative decision is not supported by "substantial evidence" where it is contrary to testimony of those who conduct examinations and surveys, there is uncontradicted sub-

jective evidence, and the only rebuttal is the opposing opinion of one who has never made surveys and who concedes unfamiliarity with the conditions and circumstances under which studies were made and upon which expert opinion is based. *Cf. Hayes v. Gardner,* 376 F.2d 517, 520-21 (4th Cir. 1967). That is the case here. The clinical surveys, testimony of witnesses, and the expert opinions of competent persons were met with the opposing view of a college professor who only criticized the over-whelming proof St. James and the Florida hospitals made in support of their claim that patient bedside telephones had therapeutic value, In fact, the Board did not disallow reimbursement of the patient telephone costs because there was a lack of evidence proving therapeutic value; it did so only because it felt bound by 42 C.F.R. § 405.310(j), the regulation proscribing such reimbursement adopted by the Secretary.

This regulation, in its pertinent part, provides that

> Notwithstanding any other provisions of this Part 405, no payment may be made for any expenses incurred for the following items or services:
>
> (a) . . .
>
> (j) Personal comfort items and services (for example a television set, or telephone service, etc.); . . .

It was promulgated by the Secretary as interpretative of 42 U.S.C. § 1395y(a)(6) which provides that "[n]otwithstanding any other provision of this title, no payment may be made under Part A or Part B for any expenses incurred for items or services–which constitute personal comfort items. . . ." Courts, however, will accord less deference to an interpretive rule than to a legislative one. *Shell Oil Company v. Federal Power Commission,* 491 F.2d. 82, 88 (5th Cir. 1974); *see O'Neill v. United States,* 281 F. Supp. 359, 363 (N.D. Ohio 1968), *aff'd,* 410 F.2d 888 (6th Cir. 1969). "An interpretive rule is simply the agency's opinion of the meaning of a statute. It does not bind a reviewing court, which must examine the interpreta-

tion just as it would approach any other question of law, although a certain deference is given to the agency's expertise. *Haddon Tp. Bd. of Ed. v. New Jersey Dept. of Ed.*, 476 F. Supp. 681, 691 (D.N.J. 1979); *cf. Skidmore v. Swift & Co.*, 323 U.S. 134, 140, 65 S. Ct. 161, 164, 89 L.Ed. 124 (1944); *see* Davis, Administrative Law Treatise § 7:8 (2d ed).

Given whatever deference this regulation deserves, it nonetheless is clear that when Congress said that there shall be no Medicare reimbursement of expenses incurred for "personal comfort items, it did not prohibit the reimbursement of costs incurred by a Medicare Provider in furnishing patients with bedside telephones. The phrase "which constitute personal comfort items . . ." is unclear; at best, it is ambiguous. *Smith v. Wehn*, 318 F.2d 325, 327 (CCPA 1963); *see City of Milwaukee v. Lindner*, 98 Wis.2d 624, 297 N.W.2d 828, 832 (1980). This being so, resort must be had to the history of the legislation because "frequently the legislative history of a statute is the most fruitful source of instruction as to its proper interpretation. . . ." *Flora v. United States*, 362 U.S. 145, 151, 80 S. Ct. 630, 633, 4 L.Ed.2d 623 (1960). What does this history show?

It appears that when the Senate considered the Medicare Act to determine whether an item or service was covered or non-covered personal, it had the Report of its Committee on Finance No. 404 which accompanied H.R.6675, the companion bill in the House. As to covered in-patient hospital benefits, it was recommended that the program pay the reasonable costs of service ordinarily provided to in-patients by hospitals (other than certain items subsequently discussed), including new services and techniques as they are adopted in the future. However, "[i]tems supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program." S.Rep. No. 404 (Finance Committee), 89th Cong., 1st Sess. (June 30, 1965), reprinted in [1965] U.S. Code Cong. & Admin. News 1943, 1967, 1969; H.Rep. No. 213 (Committee on Ways and Means), 89th Cong., 1st Sess. 25 (March 29, 1965). The report recommended that the proposed bill exclude certain health items and services from

coverage under both the hospital insurance and the voluntary supplementary medical insurance programs. For example, barred would be payments for health items or services that are not necessary for the treatment of illness or injury, or to improve the functioning of a malformed body member. Payments would be made for the rental of a special hospital bed to be used by a patient in his home only if it was a reasonable and necessary part of a sick person's treatment. It was emphasized that "[s]uch potential personal comfort items and services as massages and heat lamp treatments would only be covered where they contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member. . . . *Id.* at 1989.

Thus, there is a clear suggestion that Congress intended the test of coverage in the Medicare program to be whether a service contributed meaningfully to the treatment of an illness, an injury or to the functioning of a malformed body member. This intent can be traced to November 1963 when the House Committee on Ways and Means considered H.R.3920, a legislative proposal that preceded the Medicare Act. On that occasion, the Secretary of HEW provided a description of the supplies and services to be covered by the contemplated statute: "Extra items, supplied at the request of the patient for his convenience, such as telephones in hospitals, would not be paid for." Hearings before the Committee on Ways and Means on H.R.3920, 88th Cong., 1st and 2nd Sess., p. 41. When, however, the legislative proposals were consolidated by the Committee on Ways and Means to produce H.R.6675 reported out March 29, 1965, the reference to patient telephones was replaced by the words "television rentals". Congress was then told that "[i]tems supplied at the request of the patient for his convenience, such as television rental in hospitals, would not be paid for under the program." H.R. (Committee on Ways and Means) No. 213, 89th Cong., 1st Sess., March 29, 1965, p. 25. This legislative evolution supports the argument made by St. James Hospital in this case that the substitution of television rental as a non-reimbursable service in place of the HEW suggestion of patient telephones, establishes that Congress did not intend to make patient tele-

phones *per se* excluded from Medicare coverage. What is evident is a congressional intention to exclude such services from coverage if they are requested for the convenience of a patient and have no meaningful relation to the treatment of an illness or an injury or the functioning of a malformed body member.

In this court's judgment, St. James Hospital is correct in insisting that "[t]he determination of whether an item or service is a non-reimbursable personal comfort item or service depends upon its use and function in the delivery of health care and the recuperative process." Brief for Plaintiff at 41. The Medicare Act reimburses hospitals providing services to Medicare beneficiaries the lesser of their charges or the reasonable cost of furnishing such services. 42 U.S.C. § 1395f. "Reasonable cost" is the actual cost of providing in-patient hospital care. 42 U.S.C. § 1395x(v)(1)(A). The term "actual cost" is all inclusive unless specifically identified and the exclusions contained in 42 U.S.C. § 1395y. In view of the legislative history and the words "which constitute personal comfort items" used by Congress in 42 U.S.C. § 1395y(a)(6), the Secretary's interpretation contained in the regulation 42 C.F.R. § 405.310(j) is clearly erroneous. The simplistic prohibition of reimbursement for expenses for "[p]ersonal comfort items and services (for example, a television set or telephone service, etc.)" fails to distinguish between the telephone service furnished a patient at his request and for his comfort and a bedside telephone furnished by a hospital in the delivery of health care and the recuperative process.

Generally, the standard for reviewing a regulation governing Medicaid reimbursements is whether the regulation is reasonably related to the purposes of the statute. *Johnson's Professional Nursing Home v. Weinberger*, 490 F.2d 841, 844 (5th Cir. 1974); *cf. Arkansas Pharmacists Ass'n. v. Harris*, 627 F.2d 867 (8th Cir. 1980). Such a regulation must be upheld unless it is inconsistent with the enabling legislation. *Green v. Philbrook*, 427 F. Supp. 834, 838 (D.C. Vt. 1977), *reversed on other grounds* 576 F.2d 440 (2d Cir. 1978); and see 42 U.S.C. § 1302. In this case, 42 C.F.R. § 405.310(j) is not reasonably

related to the purposes of the Medicare Act; it is inconsistent with its objectives. The principal purpose of the Medicare program is providing Medicare beneficiaries with medical services, accomplished by the reimbursement of provider hospitals, their charges or the reasonable cost of furnishing such services, 42 U.S.C. § 1395f(a); and the Secretary is prohibited from adopting regulations which implement the statute in such a way that "the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs . . . will be borne by individuals not so covered. . . ." 42 U.S.C. § 1395x(v)(1)(A). The regulation in question prevents the paying of provider hospitals for their charges or the reasonable costs of furnishing Medicare beneficiaries with bedside telephones.

Moreover, it is inconsistent with the underlying legislation because 42 U.S.C. § 1395y(a)(6) prohibits cost reimbursements for items or services, "which constitute personal comfort items." The Secretary's subordinates acknowledged a showing that a bedside telephone furnished a patient by a hospital had therapeutic value; it is essential to the delivery of health care. A bedside telephone furnished by a hospital is not an item of comfort; it is part of hospital therapy. Accordingly, this court concludes that the Secretary's action is not supported by substantial evidence, *Memorial, Inc. v. Harris*, 655 F.2d 905, 912 (9th Cir. 1980); it is obvious that the Secretary committed an error of judgment in construing and applying 42 C.F.R. § 405.310(j) to exclude from reimbursable costs St. James incurred in furnishing Medicare patients with bedside telephones. Thus, under the circumstances, the Secretary's action was arbitrary and capricious. *Pacific Coast Medical Enterprises v. Harris*, 633 F.2d 123 (9th Cir. 1980). The refusal to reimburse these costs cannot stand. *AMI-Chanco v. United States*, 576 F.2d 320 (Ct. Cl. 1978).

IV

For the foregoing reasons, an appropriate judgment will be entered in favor of the plaintiff, St. James Hospital and against Patricia Roberts Harris, Secretary, Department of Health and Human Services.[1]

So ordered.

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[1]Patricia Roberts Harris, who is here sued only in her official capacity, has been succeeded in office by Richard S. Schweiker, However, for literary reasons, there having been no motion for substitution, the court has treated the case as against the Secretary during whose term of office this controversy arose. Under the circumstances, by operation of law, the substitution is automatic; and the judgment in this case is against the current incumbent who becomes the named defendant. *See Bracco v. Lackner,* 462 F. Supp. 436 (N.D. Cal. 1978); Fed.R.Civ.P. Rule 25(d), 28 U.S.C.A.